Wyoming County Department of Mental Health
Permission to Use and Disclose Confidential Information

This form is designed to be used by organizations that collaborate with one another in planning, coordinating and delivering services to persons diagnosed with mental disabilities. It permits use, disclosure and re-disclosure of confidential information for the purposes of care coordination, delivery of services, payment for services and health care operations. This form complies with the requirements of §33.13 of the New York State Mental Hygiene Law, federal alcohol and drug record privacy regulations (42 CFR Part 2), and federal law governing privacy of education records (FERPA) (20 USC 1232g). It is not for the use for HIV-AIDS related information. Although it includes many of the elements required by 45 CRF 164.508©, this form is not an "Authorization" under the federal HPPAA rules. An "Authorization" is not required because use and disclosure of protected health information is for purposes of treatment, payment or health care operations. (See 45 CFR 164.506).

1. **I hereby give permission to use and disclose health, mental health, alcohol and drug, and education records as described below.**
2. **The person whose information may be used or disclosed is:**
   Name: _____ Date of Birth_____
3. **The information that may be disclosed includes (check all that apply):**
   - □ **Mental Health Records**
   - □ **Health Records**
   - □ **Alcohol/Drug Records**
   - □ **School or Education Records**
   - □ **All of the records listed above**
4. **This information may be disclosed by:**
   - □ **Any person or organization that possesses the information to be disclosed**
   - □ **The following persons or organizations that provide services to me:**

     _____ _____

     _____ _____
5. **This information may be disclosed to:**
   - □ **Any person or organization that needs the information to provide service to the person who is the subject of the record, pay for those services, or engage in quality assurance or other health care operations related to that person.**
   - □ **The following organizations:**

     _____ _____

     _____ _____

This permission to disclose records applies to the following organizations and people who work at those organizations. These organizations work together to deliver services to residents of Wyoming County.

( ) Living Opportunities of DePaul (LODP)
( ) DePaul Community Services
( ) Peers Together of Wyoming County
( ) Rochester Psychiatric Center
( ) Genesee Valley BOCES Jail Case Manger
( ) RPC-Mobile Integration Team (MIT)
( ) Clarity Wellness Community
( ) Spectrum Health & Human Services
( ) Wyoming County Community Hospital
( ) Wyoming County Department of Mental Health
( ) Wyoming County Department of Social Services
( ) Wyoming County Probation Department
( ) Wyoming County Public Defender
( ) Other_____

6. **The purposes for which this information may be used and disclosed include:**
    - **Evaluation of eligibility to participate in a program supported by the Wyoming County Department of Mental Health;**
    - **Delivery of services, including care coordination and case management;**
    - **Payment for services; and**
    - **Health Care Operations such as quality assurance.**
7. **I understand that New York and federal law prohibits persons that receive mental health, alcohol or drug abuse, and education records from re-disclosing those records without permission. I also understand that not every organization that may receive a record is required to follow the federal HIPAA rules governing use and disclosure of protected health information. I HEREBY GIVE PERMISSION TO THE PERSONS AND ORGANIZATIONS THAT RECEIVE RECORDS PURSUANT TO THIS AUTHORIZATION TO RE-DISCLOSE THE RECORD AND THE INFORMATION IN THE RECORD TO PERSONS OR ORGANIZATIONS DESCRIBED IN PARAGRAPH 5 FOR THE PURPOSES PERMITTED IN PARAGRAPH 6, BUT FOR NOT OTHER PURPOSE.**
8. **This permission expires (check applicable choice)**
    □ On _____
    □ Upon the following event: _____
9. **This permission is limited as follows:**
    □ Permission only applies to records for the following time period:_____
    _____ To _____
    □ Other limitation: _____
10. **I understand that this permission may be revoked. I also understand that if this permission is revoked, it may not be possible to continue to participate in certain programs. I will be informed of that possibility if I wish to revoke this permission. I also understand that records disclosed before this permission is revoked may not be retrieved. Any person or organization that relied on this permission may continue to use or disclose records and protected health information as needed to complete work that began because this permission was given.**

I am the person whose records will be used or disclosed. I give permission to use and disclose my records as described in this document.

_____ _____
Signature Date

I am the personal representative of the person whose records will be used or disclosed. My relationship to that person is_____. I give permission to use and disclose my records as described in this document.

_____ _____
Signature Date

_____
Print Name

Rev 9/25/2019

Single Point of Access (ADULT SERVICES)

Application Form

PLEASE COMPLETE ENTIRE FORM. PLEASE ATTACH A COPY OF A RECENT PSYCHOSOCIAL EXAM, ANY AVAILABLE ASSESSMENTS OR MENTAL STATUS EXAM.

County which application is being sent to:

☐ **Chautauqua** ☐ **Erie** ☐ **Genesee** ☐ **Monroe** ☐ **Onondaga** ☐ **Wyoming**

1. REFERRAL INFORMATION	Referral is for: ☐ Care Coordination ☐ Housing ☐ Both ☐ Other: _____ Type of Service Requested: _____

Client Name: Gender: ☐ M ☐ F	Date of Referral:

Client Street Address: City/State/Zip:	Referring Person: Referring Agency and Address: Referral Contact Telephone #:
Client Phone Number: Cell phone #:	
Client SSN: Client DOB:	
Client Medicaid # (include Sequence #) _____Seq._____ Private Insurance Name and Policy #_____	Name and Phone Number of Current Outpatient Provider:
Alternate Contact, Address and/or Phone # for Client:	Emergency Contact Name, Address & Phone #:

AXIS	***DESCRIPTION***	***CODE***
Axis I (MH)		
Axis I (CD)		
Axis II		
Axis III		
Axis IV		
Axis V		

Primary Referral Organization Affiliation:

☐ Self, Family, Friend
☐ Mental Health Outpatient
☐ Local MH Practitioner
☐ Mental Health Residential
☐ CSP Mental Health Program
☐ Emergency Non-residential Program
☐ State Psychiatric Ctr (inpt)
☐ General Hospital ER
☐ General Hospital (inpt)
☐ Substance Use Program
☐ Other Medical Provider
☐ MR/DD Facility
☐ Social Services
☐ Family Court
☐ Criminal Court
☐ Probation/parole
☐ Jail
☐ Shelter for the homeless
☐ Other (specify) _____

REFERRAL INFORMATION **SPOA- Adult PAGE TWO**	NAME: Last First MI

2. PERSONAL & DEMOGRAPHIC INFORMATION

Race/Ethnicity:

☐ 1. White, Non-Hispanic
☐ 2. Black, Non-Hispanic
☐ 3. Hispanic
☐ 4. Asian
☐ 5. American Indian or Native
☐ 6. Other (specify)_____

Primary Language

☐ 1. English
☐ 2. Spanish
☐ 3. American Sign Language
☐ 4. Other_____

English Proficiency (if primary language is other than English)

☐ 1. Does not speak English
☐ 2. Poor
☐ 3. Fair
☐ 4. Good – does not need translator

3. LIVING ENVIRONMENT/SUPPORT SYSTEM

☐ **Does this individual currently receive case management or care coordination? □ No □ Yes**
If yes, agency name: _____

Current Marital Status

☐ Single, never married
☐ Currently married
☐ Cohabiting with significant other/domestic partner
☐ Divorced/separated
☐ Widowed

Custody Status of Children

☐ No children
☐ Have children- all older than 18yrs
☐ Minor children currently in client's custody
☐ Minor children not in client's custody but have access
☐ Minor children not in client's custody-no access

Living Situation at Time of Referral:

☐ Lives alone
☐ Lives with spouse
☐ Lives with parents
☐ Lives with other relatives
☐ Assisted /supported living (specify) _____
☐ Nursing home/medical setting (specify) _____
☐ Supervised Apartment Program (specify) _____
☐ Supervised group home (specify) _____
☐ Psychiatric hospital (specify) _____

☐ **Correctional setting (specify) _____**

4. EDUCATION & EMPLOYMENT VOCATIONAL STATUS

Current Education Level

☐ No formal education
☐ Some grade school (1-8th grade)
☐ Completed grade school
☐ Some HS (9-12th grade, but no diploma)
☐ HS diploma or GED
☐ Vocational, business training
☐ Some college, no degree
☐ College degree
☐ Masters degree
☐ Other:_____

Current Employment Status

☐ No employment
☐ Full-time
☐ Part-time
☐ Sheltered workshop
☐ Has job coach
☐ VESID involvement
☐ Other _____

REFERRAL INFORMATION **SPOA-Adult PAGE THREE**	NAME: Last First MI

5. NEED FOR SERVICE(S)

Item	
Please comment on each of the following areas of your life.	*Living Situation*: In 1 year, where would you like to be living? *Learning:* In 1 year, would you like to be in school or a training program? □ No □ Yes If yes, what would you like to do? *Working:* In 1 year, would you like to be working? □ No □ Yes If yes, what would you like to do? *Socializing:* In 1 year, would you like to have more connections with others? □ No □ Yes If yes, who or where would you like these connections?
What kind of support and guidance would help you (applicant) through this time in your life?	

REFERRAL INFORMATION SPOA- Adult PAGE FOUR	NAME: Last		First		MI	
Item	**1**	**2**	**3**	**4**	**5**	**Details**
Mental Health Services * *Name of Outpatient Treatment Provider*: Score:	Stable, linked with mental health services or no mental health issues identified	Needs information to link to mental health services; has the skills to complete independently	Needs linkage to mental health services and does not have the skills to initiate	Linked to mental health services but not engaging; multiple emergency room visits to manage mental health issues	Multiple mental health issues; refusing or unable to address issues	☐ Individual has had at least 2 inpatient psychiatric hospitalizations in the last 2 years OR any 1 hospitalization in the last year * If known, how many: _____ ☐ Individual has had at least 2 or more ER visits in the last year * If known, how many: _____
Substance Use Services * *Name of Outpatient Treatment Provider*: Score:	Stable, linked with substance use services or no substance use issues identified	Needs information to link to substance use services; has the skills to complete independently	Needs linkage to substance use services and does not have the skills to initiate	Linked to substance use services but not engaging	Multiple substance use issues; refusing or unable to address issues	☐ Individual has had at least 1 inpatient detoxification or rehabilitation admission in the last year *If known, how many: _____ ☐ Individual has had at least 2 or more ER visits in the last year *If known, how many: _____
Physical Health/Wellness *Name of Current Outpatient Treatment Provider(s)*: **Score:**	**Stable, linked with medical services or no medical issues identified**	Needs information to link; has the skills to complete independently	Needs linkage and does not have the skills to initiate	Linked but not engaging; multiple emergency room visits to manage medical issues	Multiple medical problems; refusing or unable to address issues	☐ No significant medical issues ☐ Incontinent ☐ Impaired walking ☐ Requires special medical equipment ☐ Hard of Hearing/ Deaf ☐ Impaired Vision/Blind ☐ Lung Problems ☐ Diabetes ☐ Heart Problems ☐ High Blood Pressure ☐ Chronic Pain ☐ Weight Problems ☐ Other:

REFERRAL INFORMATION SPOA- Adult PAGE FIVE	NAME: Last First MI

Item	1	2	3	4	5	Details
Medication Use * *Name, dosage, frequency of medications:* Score:	Medication not prescribed	Takes medication exactly as prescribed	Takes medication as prescribed most of the time	Takes medication as prescribed sometimes	Takes medications as prescribed rarely or never; refuses medications	☐ Mental illness interferes with taking prescribed medications ☐ Prescribed oral medications ☐ Prescribed injectable medications
Danger to Self or Others Score:	No apparent history or risk indicators	No apparent risk factors in at least the last 12 months	Possible risk factors for danger: there have been risk factors in the last year however the individual seems to be managing them well	Probable risk factors for danger; there have been risk factors in the last year and the individual does not seem to be managing them well	Imminent risk factors for danger; action for safety needs to take place	☐ suicidal ideation ☐ history of arson ☐ suic0idal attempt (s) ☐ perpetrator of abuse ☐ violence towards others ☐ destruction to property ☐ currently involved in domestic violent relationship ☐ other: ☐ Triggers: please specify:
Legal ***Name of Current Legal Contact (s)*: Score:	No legal charges or arrests in the last year	Charges pending; family and friends have legal involvement	Legal history and needs monitoring but following through; legal history is over a year old	On probation and continues to involve self in illegal activity; sporadic arrests; released from jail/prison in the last 30 days	Multiple and continuous arrests in the last year; currently incarcerated	Involved with: ☐ Treatment Court ☐ Involved with Child Protective Services ☐ Involved with Adult Protective Services ☐ Involved with Assisted Outpatient Treatment (AOT) ☐ Probation ☐ Parole ☐ CPL ☐ Other:

REFERRAL INFORMATION SPOA- Adult PAGE SIX	NAME: Last First MI

Item	**1**	**2**	**3**	**4**	**5**	**Details**
Housing * *Current Housing Provider:* Score:	Stable housing for over six (6) months; no current housing concerns	Stable housing for three (3) to six (6) months	Stable housing for three (3) months	Unstable housing; evictions; temporary shelter or housing; unsafe or substandard housing; concern for eviction	Homeless; living on street; living in a shelter	
Education and Employment Score:	Engaged in competitive employment without supports; actively engaged in training or education full time	Engaged in competitive employment, training or education with ongoing supports	Engaged in non-paid work experiences (ie: volunteer); have begun training or education	Temporary or sporadic employment; thinking about training or education	No history of employment of any kind; has no desire to move towards goals in either of these areas	
Economic Status * *Current Financial Contacts*: ☐ Representative Payee: Score:	Manages money without assistance; never in financial crisis	Manages money independently with assistance; rarely in financial crisis	Has some difficulty managing money with assistance; occasionally in financial crisis	Money is not managed most of the time; frequently in financial crisis	Money is not managed at all; regularly is in financial crisis	☐ Social Security ☐ SSI/SSD ☐ Public Assistance ☐ Veteran's Benefits ☐ Food Stamps ☐ Pension ☐Wages/Earned Income ☐ Worker's Compensation ☐Unemployment ☐ Sanctioned by Social Services ☐ Other:

REFERRAL INFORMATION **SPOA- Adult PAGE SEVEN**	NAME: Last First MI

Item	**1**	**2**	**3**	**4**	**5**	**Details**
Community Living Skills Score:	Has not required assistance for more than six (6) months	Has not required assistance in the last three (3) to six (6) months	Requires assistance to maintain basic needs	Basic needs are minimally met	Basic needs are not met	
ADL's (eating, hygiene, grooming, dressing, toileting)	Does not require assistance; self sufficient	Needs some verbal advice or guidance	Needs some physical help or assistance	Needs substantial assistance	Unable and/or unwilling to act independently; totally dependent	
Transportation/Use of public transportation and other community resources	Does not require assistance; self sufficient	Needs some verbal advice or guidance	Needs some physical help or assistance	Needs substantial assistance	Unable and/or unwilling to act independently; totally dependent	
Plan, shop, prepare meals, clean	Does not require assistance; self sufficient	Needs some verbal advice or guidance	Needs some physical help or assistance	Needs substantial assistance	Unable and/or unwilling to act independently; totally dependent	
Social Relationships (ability to establish or maintain satisfactory relationships)	Does not require assistance; self sufficient	Needs some verbal advice or guidance	Needs some physical help or assistance	Needs substantial assistance	Unable and/or unwilling to act independently; totally dependent	
Self direction (impulse control, decision making, judgment, etc)	Does not require assistance; self sufficient	Needs some verbal advice or guidance	Needs some physical help or assistance	Needs substantial assistance	Unable and/or unwilling to act independently; totally dependent	

I am aware of this application and the services I am requesting:

Signature of Individual: _____

Signature/Title/Agency of Person Completing Application:	**Date:**

Mail or fax completed application and release to: