

MONROE COUNTY SINGLE POINT OF ACCESSIBILITY CHILDREN'S REFERRAL PACKET

Thank you for your interest in referring to the children's specialized non-emergency mental health services of Monroe County. This form should be completed if you are referring a child/family to **Intensive Case Management, Supportive Case Management, Home and Community Based Services Waiver** and/or **Family Resiliency** services. The referral process is described below, and the following page contains information on each of the programs to help you decide the level of service needed.

Referral Process:

1. The referral agent completes referral packet, including the consent form and attaching supporting documentation. Included in this packet is a letter for parents/guardians that outlines the purpose and intention of the consent form. Please review this letter with the parent/guardian, remove it from the packet, and give it to them for future reference. The signed consent form must remain with the packet in order for the referral to be considered for services.
2. The entire packet of information is forwarded to:

Monroe County SPOA
c/o Hillside Children's Center
1183 Monroe Avenue
Rochester, NY 14620
3. The SPOA Team reviews the packet for accuracy and completeness.
4. If additional information is required/requested, a member of the SPOA team may:
 - a) contact the referring agent and/or family to obtain additional information,
 - b) coordinate with the referring agent any additional evaluations or assessments which are needed, and/or
 - c) schedule an appointment with the child/family to conduct a more thorough assessment.
5. Once the packet is complete and has been reviewed, the SPOA team in collaboration with program coordinators will determine whether the child/family is appropriate for one of the SPOA services.
6. If not appropriate for a SPOA service, the referring agent will be contacted by a member of the SPOA team and recommendations for other service options will be provided.
7. If appropriate for services, the completed packet of information will be forwarded to the coordinator of the service for review and admission/placement in the program.
8. If an opening is not immediately available and the child is placed on a services' waiting list, or there are complications in determining the appropriate level of service needed, the case may be presented at the Children's Referral Committee for special review. At that time, an interim plan will be created in collaboration with stakeholders, and a lead provider identified to provide ongoing coordination of care.
9. Please note: Often, cases will be placed on waiting lists, as openings are not readily available in these programs. As such, it is the responsibility of the referring provider and the existing service providers to be able to create and institute a plan that will safely maintain this child in the community. The SPOA is a point of entry/triage and is not a service provider; therefore, they should not be considered a component of a safety plan for the child.
10. The child/family will be placed in the appropriate service when an opening is available as long as the service is still needed. The SPOA Team will monitor current need and transitions into services.

MONROE COUNTY RESIDENTS CHILDREN'S MENTAL HEALTH SPECIAL SERVICES

	Community Based Waiver Hillside Children's Center	Children's Intensive Case Management St. Joseph's Villa of Rochester	Children's Supportive Case Management St. Joseph's Villa of Rochester	Family Resiliency Hillside Children's Center and Better Days Ahead
Ages	5-18 (can remain until 21)	5-18	5-18	5-17 (terminate at 18)
Admission Eligibility	<ul style="list-style-type: none"> ◆ Seriously Emotionally Disturbed (SED) children/adolescents with complex mental health needs. ◆ Viable, consistent and supportive home environment with parents or guardians (including DSS foster home) willing to support the child in the home and community. ◆ Imminent risk of psychiatric placement (hospital and/or RTF). ◆ Child must be Medicaid eligible based on child's income. 	<ul style="list-style-type: none"> ◆ Seriously Emotionally Disturbed (SED) children/adolescents with complex service needs in any area. ◆ Parent or guardian's involvement and participation is encouraged, but not mandatory in order for the child to be involved in services. Child can be in foster care. ◆ Imminent risk of psychiatric placement (hospital and/or RTF). 	<ul style="list-style-type: none"> ◆ (SED) children/adolescents who are engaged with mental health services but require assistance in maintaining involvement. ◆ Parent or guardian's involvement and participation is encouraged, but not mandatory in order for the child to be involved in services. Child can be in foster care. ◆ Risk of psychiatric placement (hospital and/or RTF). 	<ul style="list-style-type: none"> ◆ Seriously Emotionally Disturbed (SED) children/adolescents who are attending mental health services on a regular bases with the support of their parent or guardian. ◆ Low risk of psychiatric placement (hospital and/or RTF). ◆ Must be living with family (parent or guardian) and they must be willing to participate with services.
Services	<ul style="list-style-type: none"> ◆ Individualized, strength based services utilizing the Wrap-around resources. ◆ Home, school and community based ◆ Services provided by the Individual Care Coordinator include coordinating Wavier services and all Medicaid billable services (outpatient, transportation, medication, etc.) to assure for cost effective service delivery, coordination of clinical pathways for the child/family team, assessment of strengths and needs, advocacy, linking, monitoring, accessing flex dollars, community support development, and family/child team development. ◆ Access to services including: <ul style="list-style-type: none"> - Skill builder - Intensive in home. - Respite (hourly and daily) - Family support, crisis response. ◆ Direct crisis intervention 24-hours. ◆ Services typically involved 9-12 months 	<ul style="list-style-type: none"> ◆ Individualized, strength based services utilizing the Wrap-around resources. ◆ Home, school & community based ◆ Services provided by the Intensive Case Manager include: assessment; advocacy; planning; monitoring; linking; access to flex dollars; community support development and family/child team development. ◆ Coordinate services to assure efficient, cost effect service delivery for the whole family ◆ Crisis service supports through 24-hour phone supports. ◆ Youth can be placed on in-active status following ICM service where they can be monitored for future service needs. 	<ul style="list-style-type: none"> ◆ Individualized, strength based services utilizing the Wrap-around resources. ◆ Home, school & community based ◆ Services provided by the Supportive Case Manager include: assessment; advocacy; planning; monitoring; linking; access to flex dollars; community support development and family/child team development. ◆ Coordinate services to assure efficient, cost effect service delivery for the whole family. ◆ Crisis service supports through 24-hour phone supports. 	<ul style="list-style-type: none"> ◆ Individualized services provided through Wrap-around resources. ◆ Outreach, home based services to parents. ◆ Services provided by a Parent Mentor or a Case Advocate (who are supervised by a MSW) Child mentors and include: planning, advocacy, monitoring, linking, and access to flex dollars. ◆ Crisis intervention is deferred to other programs.
Frequency	Average of 6-15 hours of Waiver specific services per week. Caseloads 5:1	Average of one contact per week with the youth, plus case work Caseloads 12:1.	Averages bi-monthly visits with the youth, plus casework. Caseload 20:1.	Average one contact per week for the first 3 months, then bi-monthly visits. Caseload 14:1.

Monroe County SPOA Team
Hillside Children's Center
1183 Monroe Ave.
Rochester, NY 14620

DATE:

Dear Parents/Legal Guardian:

Your child _____ has been referred to the Monroe County Single Point of Accessibility Team (also known as SPOA) by _____. The purpose of the SPOA team is to match your child's clinical needs with programs. To best assist you and your child to get the most appropriate level of services, the SPOA team may need additional information from your child's school, mental health or substance abuse provider, medical doctor; probation officer or DSS case worker.

The attached releases of information give consent for each provider of services to release information to the SPOA Team. The purpose for releasing the information is to assist the SPOA Team in making appropriate referrals.

At times, due to the complexity of your child and family's needs, the SPOA manager may request to discuss your child's case with the Monroe County Children's Referral Committee. This committee is made up of representatives from the following organizations:

Better Day Ahead; Berkshire Farms; Crestwood Children's Center; Hillside Children's Center; Monroe County Offices of Mental Health and Probation; Coordinated Children's Services Initiative; St. Joseph's Villa; Strong Memorial Hospital; Unity Health System; Via Health System, Department of Social Services; Rochester Psychiatric Center; Single Point of Accountability Team; Coordinated Care Services, Inc.

It may also include a representative from your child's school, if appropriate. Parents are encouraged to attend their child's meeting either in person or by phone. The enclosed release will allow information gathered by the SPOA Team to be shared with members of the committee.

If you have any questions regarding the releases of information, please feel free to discuss them with your provider or call the SPOA team at 716-256-7654.

Respectfully yours,

Monroe County SPOA Team

**MONROE COUNTY OFFICE OF MENTAL HEALTH
 CONSENT FOR RELEASE OF INFORMATION FOR CHILDREN'S SERVICES**

Child's Name (Last, First, MI)	Sex	Age	Date of Birth
Parent(s)/Guardian Name			

INFORMATION TO BE RELEASED TO:

Monroe County Single Point of Accessibility Team & Children's Referral Committee	And the following participating programs for ongoing service: <input type="checkbox"/> Intensive Case Management <input type="checkbox"/> Home and Community Based Services Waiver <input type="checkbox"/> Family Resiliency
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(Committee membership includes representatives from: Better Days Ahead, Berkshire Farms, Crestwood Children's Center, Hillside Children's Center, Monroe County Offices of Mental Health & Probation, St. Joseph's Villa, Strong Memorial Hospital, Unity Health System, Via Health System, Department of Social Services, Rochester Psychiatric Center, & Coordinated Care Services, Inc.)

BY THE ORGANIZATIONS LISTED BELOW:

(Organization Name, Address and Phone)	Purpose:
(Organization Name, Address and Phone)	Purpose:
(Organization Name, Address and Phone)	Purpose:
(Organization Name, Address and Phone)	Purpose:

- I hereby give permission for the periodic release of the above information to the Organization(s) identified above as often as necessary to plan and provide services for my child. I understand that the information to be released is confidential and protected from disclosure. I also understand that I have the right to cancel my permission to release information at any time. (My consent to release information to the organization(s) identified above will expire when I am no longer receiving services from that organization, or one year from this date, whichever occurs first.)
- I hereby give permission for the one-time release of information to the Organization(s) identified above. I understand that the information to be released is confidential and protected from disclosure. I also understand that I have the right to cancel my permission to release information at any time. (My consent to release information will expire when acted upon, or 90 days from this date, whichever occurs first.)
- (Check the box next to the paragraph that applies and cross-out the paragraph that does not apply)***

_____ Parent/Guardian Signature	_____ Witness Signed
_____ Relationship	_____ Date
_____ Date Signed	
_____ Signature of Staff Person Releasing Information	Title: _____
	Date Released: _____

**MONROE COUNTY OFFICE OF MENTAL HEALTH
SINGLE POINT OF ACCESSIBILITY REFERRAL FORM**

PROGRAM REFERRED TO:

- ___ Family Resiliency Services (Referral completed with family and primary therapist)
- ___ Case Management: ___ Intensive ___ Supportive
- ___ Home and Community Based Services Waiver

Date of Referral: _____

Child's Name: _____ D.O.B.: _____
Last name First name

Child's Residence: _____
Street Address

City/Town _____ State _____ Zip _____

Phone: _____ Child's Social Security # _____ - _____ - _____ Gender (circle one): *male* *female*

Ethnicity (check one): White (Non-Hispanic) Black (Non-Hispanic)
 Latino/Hispanic Asian/Asian-American
 Native American Pacific Islander
 Other or dual (specify): _____

Primary Language: English Spanish Chinese Creole French
 Russian German Greek Italian Japanese
 Urdu Hindi American Sign Language Vietnamese
 Other: _____

Parent/Guardian: _____ Relationship to child: _____
Last name First name

Custody Status: Biological parents Adoptive parents Other family or legal guardian
 Local DSS OCFS (DFY) Emancipated minor
 Other: _____

Address: _____
Street Address

City/Town _____ State _____ Zip _____

Phone (H): _____ (W): _____

Client's Living Situation at Time of Referral:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Independent Living | <input type="checkbox"/> DSS Family Foster Care | <input type="checkbox"/> Crisis Residence | <input type="checkbox"/> Jail |
| <input type="checkbox"/> Lives w/other relatives | <input type="checkbox"/> OMH C & Y Residence | <input type="checkbox"/> Shelter for homeless | <input type="checkbox"/> Homeless (streets) |
| <input type="checkbox"/> Two parent family | <input type="checkbox"/> Teaching Family Home | <input type="checkbox"/> Residential School | <input type="checkbox"/> OCFS(DFY) Facility |
| <input type="checkbox"/> One parent family | <input type="checkbox"/> DSS Group Home | <input type="checkbox"/> Residential Treatment Center (DSS) | |
| <input type="checkbox"/> Two parent adoptive family | <input type="checkbox"/> OCFS (DFY) Group Home | <input type="checkbox"/> Residential Treatment Facility (OMH) | |
| <input type="checkbox"/> One parent adoptive family | <input type="checkbox"/> Family Based Treatment | <input type="checkbox"/> Psychiatric Inpatient Care | |
| <input type="checkbox"/> Relative's family | <input type="checkbox"/> DSS Specialized Foster Care | <input type="checkbox"/> Unknown | |
| <input type="checkbox"/> Other: _____ | | | |

Who lives in the home:

Name:	Relationship to the client:
_____	_____
_____	_____
_____	_____
_____	_____

REFERRAL INFORMATION

Referral Source:

- Self Family, friend, legal guardian Any residential program
- DSS MR/DD Any shelter, respite, crisis, child/foster care
- Article 31 hospital General hospital State Hospital
- Emergency Room Case Manager Outpatient Clinic/Day Treatment Program
- Juvenile Justice System School/Educational setting
- Homeless outreach program, drop-in or reception center Other: _____

Referred by (name): _____ Agency: _____

Phone: _____ Address: _____

Contact person (if different): _____ Agency: _____

Phone: _____ Address: _____

Reason for Referral: _____

Identified Concerns/Problems (per parents): _____

What are the identified family/child **NEEDS**; what services are needed and/or anticipated? _____

EDUCATIONAL STATUS

Present educational placement (check all that apply):

- Regular class, in age appropriate grade Regular education, but at least one class behind
- Special class for students w/handicapping conditions Residential school of educationally/emotionally handicapped
- Full-time vocational training only Not enrolled in school
- Part-time vocational/educational Day Treatment
- HS graduate/GED BOCES
- Home instruction
- Other: _____

School District: _____ Present Placement Type: _____

Present Placement Location: _____

Current Educational Activity (check all that apply):

- Currently enrolled Suspended, Days: _____ Expelled Truant

Highest grade level achieved:

- 1st 2nd 3rd 4th 5th 6th 7th 8th 9th 10th 11th 12th
- Ungraded Other

FINANCIAL/HEALTH INSURANCE

Entitlements and Income: (Check appropriate column-item from HRA)

*** Please note benefits or insurance currently received by client and/or parent/guardian.**

Benefits or Insurance	Currently receives	Pending – application submitted	Eligible – no application submitted	Ineligible	Unknown
Social security	()	()	()	()	()
SSI/SSD	()	()	()	()	()
Public Assistance	()	()	()	()	()
Veterans	()	()	()	()	()
Medicare /Medicaid	()	()	()	()	()
Food stamps	()	()	()	()	()
Pension	()	()	()	()	()
Wages/ earned income	()	()	()	()	()
Worker’s Comp	()	()	()	()	()
Unemployment	()	()	()	()	()
Private insurance/ third party payor	()	()	()	()	()
Trust fund	()	()	()	()	()
Medication Grant	()	()	()	()	()
Other	()	()	()	()	()

Does the child have income of their own (if yes, please specify): _____ No _____ Yes, specify: _____

Does the child have resources of their own (if yes, please specify): _____ No _____ Yes, specify (include stocks, bonds, savings, etc.): _____

Health insurance: Plan: _____ Number: _____

MEDICAL INFORMATION

Functional Medical Problems (check all that apply):

- () None
- () Incontinent
- () Impaired ability to walk
- () Impaired vision
- () Speech Impairment
- () Learning Disability
- () Developmental Delays
- () Hearing impairment
- () Requires special medical equipment
- () Other medical problem/condition

Any other medical issues/illnesses: _____

Current Medications (dosage/frequency)

CHILD PSYCHIATRIC & SERVICE HISTORY

DSM IV Diagnosis (include code):

Axis I:	Axis III:
Axis I:	Axis IV:
Axis II:	Axis V: Current GAF: _____ Highest in past year: _____

Name of person making diagnosis: _____ Date diagnosis made: _____

IQ: Verbal: _____ Performance: _____ Full Scale: _____ Date of testing: _____

Indicate the child's involvement in the areas below:

	<u>Present</u>	<u>Past</u>	<u>Describe</u>
No prior service			
State Psychiatric Center			
General Hospital			
Private Psychiatric Center			
Mental health residential			
Mental health outpatient			
CSP mental health program			
Case Management			
Emergency mental health			
Local mental health practitioner			
DSS			
MR/DD			
Other, please specify:			
Child Protective Services			
Preventive Services			
PINS			
PINS Diversion			
Juvenile Delinquent			
Restricted Juvenile Delinquent			
Juvenile Offender			
Family Court			
Other Criminal Justice, please specify:			

Specify the following:

Number of psychiatric hospitalizations in the past 12 months: _____

Number of ER/Crisis Team visits in past 12 months: _____

Number of out-of-home placements in past 12 months: _____

Involvement with Child Protective Services within the past 12 months: _____ Yes _____ No

Current Case Management/ACT: _____ Yes _____ No

Risk factors:

- | | | |
|---|-----|----------------------|
| 1. Suicidal ideation | yes | no |
| 2. Suicide attempts (specify date of last episode: _____ and method _____) | yes | no |
| 3. Violence to others (specify date of last episode: _____) | yes | no |
| 4. Child has access to firearms in the home | yes | no |
| 5. Significant psychotic symptoms (hallucinations, delusions, bizarre behavior) | N/A | past history present |
| 6. Sexually abused (specify date of last episode: _____) | N/A | past history present |
| 7. Physically abused (specify date of last episode: _____) | N/A | past history present |

Risk Factors (con't)

8. Sexually aggressive (specify date of last episode:_____)	N/A	past history	present
9. Fire-setting (specify date of last episode:_____)	N/A	past history	present
10. Destruction of property (specify date of last episode:_____)	N/A	past history	present
11. Domestic Violence in home (specify date of last episode:_____)	N/A	past history	present
12. Homelessness (specify date of last episode:_____)	N/A	past history	present
13. Physical or medical neglect	N/A	past history	present
14. Psychological or social neglect	N/A	past history	present
15. Self-destructive behaviors	N/A	past history	present
16. At-risk of psychiatric placement or other out-of-home placement due to emotional disturbance	N/A	past history	present
17. Runaway behavior (specify date of last episode:_____)	N/A	past history	present

Please indicate the degree to which this child exhibits the following symptoms or behaviors, which are attributable to an emotional disorder:

Check if present

- 1. Depressed Mood
- 2. Anxiety / Nervousness
- 3. Suicidal symptoms (attempts, threats, or ideation)
- 4. Mood Swings
- 5. Anger/temper tantrums
- 6. Hyperactivity (problems with attention, destructible, impulsive)
- 7. Aggressive behavior (physical/sexual)
- 8. Irritability
- 9. Psychotic symptoms (hallucinations, delusions, bizarre behavior)
- 10. Obsessive/compulsive behavior
- 11. Sleep problems
- 12. Elimination problems (bowel, bladder)
- 13. Eating problems
- 14. Phobias and fears
- 15. Cruelty to animals
- 16. Fire-setting
- 17. Inappropriate sexual behavior/acting out
- 18. Antisocial / delinquent behavior

Circle degree if applicable

- | | | |
|------|----------|--------|
| mild | moderate | severe |
| mild | moderate | severe |
| mild | moderate | severe |
| mild | moderate | severe |
| mild | moderate | severe |
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| mild | moderate | severe |
| mild | moderate | severe |
| mild | moderate | severe |
| mild | moderate | severe |

FUNCTIONAL IMPAIRMENT SCALE AND SERVICES NEEDED (circle one number under each category)

SELF CARE:

- 0 - Able to maintain appropriate hygiene and daily maintenance
- 1 - Good, but needs some assistance and guidance
- 2 - Needs frequent assistance or support
- 3 - Very poor skills, Does not respond/react to support, or no supports are available

Demonstrated by: _____

EATING AND SLEEP PATTERNS:

- 0 - Maintains good/appropriate patterns
- 1 - Maintains adequate patterns with some guidance
- 2 - Poor patterns. Requires constant guidance
- 3 - Unable/unwilling to maintain patterns. Does not respond to guidance

Demonstrated by: _____

AFFECT AND/OR THOUGHT CONTENT:

- 0 - No disturbance in affect/thought or successfully controlled through medication and/or therapeutic intervention
- 1 - Occasional episode. Mediation and/or therapy somewhat successful
- 2 - Frequent episodes. Interventions provide minimal effect
- 3 - Consistently present. Interventions have had no effect

Demonstrated by: _____

SELF-DIRECTION/SELF-CONTROL:

- 0 - Independently makes good decisions. Does not put self/others at risk of harm. Independently, expresses anger appropriately (i.e. uses words etc)
- 1 - Needs some direction/guidance in above areas
- 2 - Needs frequent direction/guidance in above areas
- 3 - Unable to utilize supports and/or very poor anger management skills

Demonstrated by: _____

SOCIALIZATION: (with peers and adults)

- 0 - Able to develop and maintain relationships. Age appropriate social skills
- 1 - Needs some direction/guidance in above area
- 2 - Needs high structured environments to be successful
- 3 - Refuses or unable to socialize, even with supports

Demonstrated by: _____

FAMILY LIFE:

- 0 - Has good relationships with family members. Respects parental authority
- 1 - Infrequent conflict, but uses supports to resolve conflict
- 2 - Poor relationships, lack of respect for parent figure and/or siblings
- 3 - Extreme conflict. Complete breakdown of parental authority and communication

Demonstrated by: _____

ACADEMIC FUNCTIONING: (attendance and performance)

- 0 - Independently attends school and completes school expectations
- 1 - Occasionally absent, or requires some encouragement and/or support
- 2 - Needs high structure and constant support to attend and complete expectations
- 3 - Unable/unwilling to attend school. Total lack of motivation and participation

Demonstrated by: _____

SUBSTANCE USE HISTORY

Drugs of choice: () None () Any IV Drug Use () Alcohol () Marijuana/Cannabis
 () Cocaine () Heroin/Opiates () Crack () Hallucinogens
 () PCP () Amphetamines () Benzodiazapines () Sedative/hypnotic
 () Prescription drugs () Inhalants (sniffing glue, household products)
 () Other: _____

Use: () Not in the last month () 1-3 times in the last month () 1-2 times/week
 () 3-6 times/week () Daily

Chemical Dependency Treatment: () Yes () No If yes, specify: () Inpatient () Outpatient

PROVIDER INFORMATION

Current & Past Provider Information:

Name	Agency Affiliation	Phone #	Service Provided	✓ if past	✓ if present

If no current services, please specify date of last services: _____

Has there been a recent case conference including all the providers and family? _____Yes _____No

Describe: _____

What has been helpful with previous providers? _____

What obstacles or barriers were faced according to the parent(s): _____

FAMILY PSYCHIATRIC & SERVICE HISTORY

Indicate parent/sibling involvement in the areas below:

	<u>Present</u>	<u>Past</u>	<u>Please specify which family member and describe:</u>
Drugs/Alcohol			
Special Education			
Child Protective			
Preventive Services			
Probation			
Police/criminal			
Court System			
Mental Health Services			

CURRENT FAMILY FUNCTIONING

Identify interests that may be useful in the treatment process.

<u>Family interests:</u>	<u>Child's interests:</u>

Identify strengths that may be useful in the treatment process.

<u>Family strengths:</u>	<u>Child's strengths:</u>

****For potential referrals to the HCBS Waiver: please check one**

- Currently resides in an institutional placement and has resided in such a hospital for at least 180 consecutive days, or
- Had resided in an institutional placement within the past 6 months and was hospitalized for at least 30 consecutive days, or
- Is eligible for institutional placement, including a hospital which provides intermediate or long-term care and treatment, or
- Has applied for institutional placement, including a hospital which provides intermediate or long-term care and treatment

Please attach any available case history summaries (diagnostic, medical, educational, legal, etc.) and forward to:
Monroe County SPOA, 1183 Monroe Avenue, Rochester, NY 14620. Fax #: (716) 256-7880

Signature of person completing the form

Date: _____

Signature of parent/family member or statement of involvement
or awareness of this referral

Date: _____

For office use only:

Recommended for Service Date: _____

Program & Agency: _____

Status: _____

Approval Signatures:

Program Coordinator/Director

Date: _____

Monroe County OMH Representative

Date: _____

Denied for Service Date: _____

Reason: _____

Alternate Recommendation: _____

Party responsible for follow-up: _____