Children and Youth Evaluation Service
Your Connection to Home and Community-Based Services

Home and Community Based Services (HCBS) Referral Form

PO Box 5008
New York, NY 10275

Complete this form when referring a child/youth to C-YES for HCBS eligibility determination and HCBS coordination services.

Check the following are included with this referral:

- ❑ This completed and signed Referral Form
- ❑ Most recent information related to assessments, clinical, treatment and service information, as available.
- ❑ If the referent is other than the child, parent, legal guardian, caregiver or legally authorized representative, **a signed HIPAA compliant consent form** indicating the child or their legally authorized representative's approval to share their protected health, mental health and/or substance use information with C-YES.

What is the child's/youth's annual HCBS eligibility/Level of Care (LOC) reassessment date? (If applicable)

___ ___ / ___ ___ / ___ ___ ___ ___
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PART 1 Child or Youth Demographic Information

This Part must be completed.
Fill in the child or youth's personal information. Be sure to give the child or youth's:

- Complete name and demographic information
- Medicaid Client Identification Number (CIN), if known
- Social Security Number (SSN), if known
- Primary language or communication method
- Current living arrangement
- Insurance type and, if private insurance, the insurance name and policy number, if known

1. Child or youth first name: ____________________ MI: ___ Last name: ____________________

2. Date of Birth: ___ ___ / ___ ___ / ___ ___ ___ ___
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Part 1 *continued on the next page* ⇨

QUESTIONS?

If you have questions about this form, call C-YES at
1-833-333-CYES (1-833-333-2937) TTY: 1-888-329-1541
Monday to Friday, from 8:30 am to 5:30 pm
Saturday, from 9:00 am to 12:00 pm

Part 1 *(continued)*

3. Gender: ❑ Male ❑ Female ❑ Other Gender expression: ______________________________

4. Medicaid Client Identification Number (CIN) (if applicable): ___ ___ ___ ___ ___ ___ ___ ___

5. Primary language spoken and understood by child or youth: ______________________________

6. Social Security Number (SSN): ___ ___ ___ - ___ ___ - ___ ___ ___ ___

7. Current or primary address:

______________________________	______________________________
City	County
______________________________	___ ___ ___ ___ ___
State	ZIP Code

8. Please check the one where the child or youth lives now:
   - ❑ Parent or legal guardian's home
   - ❑ Relative's home
   - ❑ Foster care
   - ❑ Out-of-home placement such as institution, hospital, nursing home or rehabilitation facility
     Describe: ______________________________
   - ❑ Other: ______________________________

9. Insurance type
   - ❑ No Medicaid
   - ❑ Medicaid: ___ Regular Medicaid (Fee for Service) or ___ Medicaid Managed Care Plan
   - ❑ Third party or private insurance

     Plan name: ______________________________

     ID or Policy number: ______________________________

PART 2 Parent, Legal Guardian, Caregiver or Legally Authorized Representative Contact Information

This Part must be completed. *The parent, legal guardian, caregiver or legally authorized representative must fill in this information for the child/youth who are under 18 years old, and are not pregnant, a parent and/or married. Be sure to:*

- Write your complete name, address and contact information
- If listing more than two contacts, write their names and contact information on a new page and attach it to this *Referral Form*

Part 2 *continued on the next page* ⇨

Part 2 (continued)

- Complete all information below to allow communication with primary contacts
- Show the relationship with the child or youth, including whether the person is a primary contact, parent, legal guardian, caregiver or legally authorized representative. Check all that apply.
- Give the contact's primary language
- Please make every effort to complete the below information

CONTACT PERSON # 1:

Name:

First: ______________________________ MI: ____ Last: ______________________________________

Are you the primary contact? ❑ Yes ❑ No

Check one: ❑ Parent ❑ Legal guardian ❑ Caregiver ❑ Legally authorized representative

Current or primary address: ____

City: ____ State: ______ ZIP Code: __ __ __ __ __

Primary language: ____________________________ Email address: _____________________________

Home number: (__ __ __) __ __ __ - __ __ __ __ Work number: (__ __ __) __ __ __ - __ __ __

Cell number: (__ __ __) __ __ __ - __ __ __ __ Can we send you text messages? ❑ Yes ❑ No

CONTACT PERSON # 2:

Name:

First: ______________________________ MI: ____ Last: ______________________________________

Are you the primary contact? ❑ Yes ❑ No

Check one: ❑ Parent ❑ Legal guardian ❑ Caregiver ❑ Legally authorized representative

Current or primary address: ____

City: ____ State: ______ ZIP Code: __ __ __ __ __

Primary language: ____________________________ Email address: _____________________________

Home number: (__ __ __) __ __ __ - __ __ __ __ Work number: (__ __ __) __ __ __ - __ __ __

Cell number: (__ __ __) __ __ __ - __ __ __ __ Can we send you text messages? ❑ Yes ❑ No

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(Continued)

PART 3 Referent Information

This Part must be completed. *The person or organization submitting the referral must fill in this part. Be sure to:*

- Identify the source of this referral
- Give complete name, title, address and contact information
- Give the Health Commerce System identification number (HCS), if applicable

Referrer:

- ❑ Community provider
- ❑ Treating professional
- ❑ Family member
- ❑ Other (Explain): ________________________________

Name of person making the referral:

First: ____________________ MI: ____ Last: ____________________

Organization name (if applies): ________________________________

Address: ________________________________

City:____________________ State:______ ZIP Code:__________

Phone number: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ Fax: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

HCS User ID: ____________________ Email address: ____________________

PART 4 Based on your knowledge of the child or youth, check *all* services you recommend to help keep the child or youth in their home, school, and community.

Complete this Part if available. *Please be sure to check all recommended services that would help keep the child or youth in their home, school, and community.*

- ❑ Community Habilitation
- ❑ Community Self-Advocacy Training and Support
- ❑ Day Habilitation
- ❑ Prevocational Services
- ❑ Supported Employment
- ❑ Youth Peer Support and Training
- ❑ Crisis Intervention
- ❑ Respite (Planned or Crisis)
- ❑ Caregiver/Family Support and Services
- ❑ Family Peer Support Services
- ❑ Environmental Modifications
- ❑ Vehicle Modifications
- ❑ Adaptive and Assistive Equipment
- ❑ Palliative Care
- ❑ Non-Medical Transportation

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(Continued)

PART 5 Health and Behavioral Health History (past 6 months)

Complete this Part if available. *The child or youth's PCP, specialist, behavioral health provider, or the person who is referring the child/youth can fill in this part. Check* ***all*** *health services used in the past* ***6 months.***

- ☐ Outpatient mental health treatment
- ☐ Outpatient substance use treatment
- ☐ Emergency room visit for psychiatric condition
- ☐ Medical and/or psychiatric hospitalization
- ☐ Emergency room visit for health condition
- ☐ Past residential or out-of-home placement (Describe): ______________________

____

____

PART 6 Current Health and Behavioral Health

Complete this Part if available. *The child or youth's PCP, specialist, behavioral health provider, or the person who is referring the child/youth can fill in this part.*

Check all current health and behavioral health statuses that apply.

- ☐ Medically fragile
- ☐ Serious Emotional Disturbance Determination
- ☐ Developmentally disabled and in foster care
- ☐ Developmentally disabled and medically fragile
- ☐ Complex trauma; emotional, physical
- ☐ Chronic conditions (one or more)
  Names:
  ____
  ____
  ____
  ____

Please provide the current Diagnostic and Statistical Manual of Mental Disorders (DSM) – V diagnosis. Only fill in this part if within scope of practice or with documents from appropriate provider. Give the current health and/or behavioral health provider's name and telephone number in ***Primary Provider's Information.***

DSM – V ____

____

____

Primary Provider's Information:

Name:____

Contact number: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

Name:____

Contact number: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

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(Continued)

PART 7 Signature of Referent

This Part must be completed. *The person referring the child or youth must fill in this part. If the referent is the parent, legal guardian, caregiver or legally authorized representative, please sign below.*

Referent must fill in this part:

By signing this form, I am submitting a HCBS referral for the child or youth listed in Part 1.

Name of referent (print): ______________________________

Signature: ______________________________ Date: __ __ /__ __ /__ __ __ __
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Part 8 DOES NOT replace a **signed HIPAA compliant consent form** when the referent is other than the child, parent, legal guardian, caregiver or legally authorized representative.

PART 8 Authorization for Referral and Release of Information: Written release is required when sharing personal health information (PHI) during a referral

This Part must be completed *only when the referent is the child/youth, parent, legal guardian, caregiver or legally authorized representative.*

- ***Self-consenting Children and Youth must fill in this information***
  - ***Children/youth who are 18 years old or older, or***
  - ***Children/youth who are under 18 years of age who are pregnant, a parent and/or married***
- ***The parent, legal guardian, caregiver or legally authorized representative must fill in this information for the child/youth who are under 18 years old, and are not pregnant, a parent and/or married***

By signing below, I am giving written consent to share ______________________________'s personal health information (PHI) during a referral.
(Child or youth's name)

Written consent and release:

Name of person giving the written consent:

First: ______________________ MI: ____ Last: ______________________

Relationship to child or youth: ______________________________

Signature: ______________________________

Date of written approval: ___ ___ /___ ___ / ___ ___ ___ ___
M M D D Y Y Y Y

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Children's Single Point of Access Application Part 1

Child's Name ______________________

REQUIRED CONSENT FOR RELEASE OF INFORMATION for Single Point of Access (SPOA) for Children's Services

This authorization must be completed by the referred individual or his/her legal guardian to use/disclose Protected Health Information (PHI) in accordance with state and federal laws and regulations that govern the release of confidential records, as well as Title 42 of the Code of Federal Regulations that governs the release of drug & alcohol records. A separate authorization is required to use or disclose confidential HIV Information.

CHILD'S NAME: ______________________ **Child's DOB:** ______________________

COUNTY(IES): ______________________

I authorize an exchange of PHI between the Single Point of Access (SPOA) Committee AND OTHER AGENCY/PERSON providing information to the committee (Please see attached list of agencies from which the SPOA Committee is permitted to request information):

AND: Referral Source (Person / Title / Agency or School):

____

Description of information to be used / disclosed is as follows: (Please check ALL that apply) ☐ **All**

☐ Referral Packet
☐ Diagnosis
☐ Financial Status
☐ Physical Exam History
☐ School Records
☐ Physician's Authorization for Restorative Services
☐ Psychological & Neurological Tests
☐ Discharge Summary / Treatment Plans
☐ Psychosocial History & Assessment
☐ Inpatient/Outpatient History
☐ Psychiatric Assessment
☐ Other (progress notes)

Purpose or need for information:

By the individual or his/her personal representative to facilitate participation in services through SPOA, and through Health Homes Serving Children.

Note: If the same information is to be disclosed to multiple parties for the same purpose, for the same period of time, this authorization will apply to all parties listed on the attached list.

Thereby permit the use/disclosure of the indicated PHI to the Person/Organization/Facility/Program identified above. I understand that:

- Only this information may be used/disclosed as a result of this authorization;
- This information is confidential and cannot legally be disclosed or re-disclosed without my permission;
- If this information is disclosed to someone who is not required to comply with federal privacy protection regulations, then it may be re-disclosed and would no longer be protected;
- I have the right to take back this authorization at any time. This revocation must be in writing on a form provided by the County government. I am aware that my revocation does not affect information already disclosed because of my earlier authorization;
- Signing this authorization is voluntary and my refusal to sign will not affect treatment, payment, enrollment or eligibility benefits;
- I have the right to inspect and copy my own PHI to be used/disclosed as provided in 45CFR 164.524.

I hereby authorize the periodic use or disclosure of the information described above to the Person/Organization/Facility/Program identified as often as necessary to fulfill the purpose identified above, and this authorization will expire: **(Initial ONE)**

☐ When the child named herein is no longer receiving Services through the Single Point of Access Process in *(fill in county(ies))*
______________________ Counties

☐ One Year from the date below

☐ Other: ______________________

I hereby authorize the one-time use or disclosure of the information described above to the Person/Organization/Facility/Program identified above and this authorization will expire:

☐ When acted upon ☐ Other: ______________________

I certify that I authorize the use of the health information as set forth in this document. By signing this authorization, I acknowledge that I have read and understand it. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability from the disclosure of the above information to the extent indicated and authorized herein.

______________________ ______________________ ______________________

SIGNATURE of PARENT or LEGAL GUARDIAN **Printed Name of Parent/Legal Guardian** **Date**

______________________ ______________________ ______________________

SIGNATURE of WITNESS **Printed Name of Witness** **Date**

"I HAVE WITNESSED THE EXECUTION OF THIS AUTHORIZATION."

List of agencies with which the SPOA Committee is permitted to exchange information

Essex County Mental Health Services

NYS Department of Health (DOH)

NYS Office of Mental Health (OMH)

Families First of Essex County/HCBS/Health Homes/CFTSS provider

CYES of Maximus (state designated independent entity)

Adirondack Community Action Programs of Essex County (ACAP)

Essex County NY DSS/CPS/Preventive/Foster Care/Probation

Youth Advocate Program (YAP)

Hudson Headwaters Health Network

St. Joes Outpatient Programs

Champlain Valley Physician's Hospital: Adolescent/Adult MHU

Office of Persons with Developmental Disability (OPWDD)

Essex County School Districts

Essex County Public Health (Early Intervention)

Four Winds of Saratoga and Katonah

Nothern Rivers/Northeast Parent and Childs/Parsons

Berkshire Farms

Adirondack Health Institute (AHI)

Adirondack Youth Lodge

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Children's Single Point of Access Application Part 1

Child's Name ____________________

Optional Children's Single Point of Access (C-SPOA) Patient Information Retrieval Consent

____
Name of SPOA County

By signing this form, you agree to have your child's health information shared with the SPOA Committee. The goals of the SPOA Committee are to improve the integration of medical and behavioral health and to help healthcare providers improve quality of care. To support coordination of your child's care, health care providers and other people involved in such care need to be able to talk to each other about your child's care and share health information with each other to give your child better care. Your child will still be able to get health care and health insurance even if you do not sign this form.

The SPOA Committee may get health information, including your child's health records, through a computer system run by____________________, a Regional Health Information Organization (RHIO) and/or a computer system called PSYCKES run by the New York State Office of Mental Health. A RHIO uses a computer system to collect and store health information, including medical records, from your child's doctors and health care providers who are part of the RHIO. The RHIO can only share your child's health information with people who you say can see or get such health information. PSYCKES is a computer system to collect and store health information from doctors and health care providers to help them plan and coordinate care.

If you agree and sign this form, the SPOA Committee members are allowed to get, see, read and copy, and share with each other, ALL of your child's health information (including all of the health information obtained from the RHIO and/or from PSYCKES) that they need to arrange your child's care, manage such care or study such care to make health care better for patients. The health information they may get, see, read, copy and share may be from before and after the date you sign this form. Your health records may have information about illnesses or injuries your child had or may have had before; test results, like X-rays or blood tests; and the medicines your child is now taking or has taken before. Your child's health records may also have information on:

1. Alcohol or drug use programs which you are in now or were in before as a patient;
2. Family planning services like birth control and abortion;
3. Inherited diseases;
4. HIV/AIDS;
5. Mental health conditions;
6. Sexually-transmitted diseases (diseases you can get from having sex);
7. Social needs information (housing, food, clothing, etc..) and/or
8. Assessment results, care plans, or other information you or your treatment provider enter into PSYCKES.

Health information is private and cannot be given to other people without proper permission under New York State and U.S. laws and rules. The providers that can get and see your child's health information must obey all these laws. They cannot give your child's information to other people unless an appropriate guardian agrees or the law says they can give the information to other people. This is true if health information is on a computer system or on paper. Some laws cover care for HIV/AIDS, mental health records, and drug and alcohol use. The providers that use your child's health information and the SPOA Committee must obey these laws and rules.

Please read all the information on this form before you sign it.

☐ **I AGREE** that the SPOA Committee can get ALL my child's health information through the RHIO and/or through PSYCKES to give my child care or manage my child's care, to check if my child is in a health plan and what it covers, and to study and make the care of all patients better. I also AGREE that the SPOA Committee and the health provider agencies may share my child's health information with each other. I can change my mind and take back my consent at any time by signing a Withdrawal of Consent Form and giving it to one of the SPOA participating providers.

______________________________	______________________________
Print Name of Patient	Patient Date of Birth
______________________________	______________________________
Signature of Patient or Patient's Legal Representative	Date
______________________________	______________________________

Children's Single Point of Access (C-SPOA)
Patient Information Sharing Consent

Details About Patient Information and the Consent Process

1. **How will SPOA providers use my information?**

If you agree, SPOA providers will use your health information to:

- Coordinate your health care and manage your care;
- Check if you have health insurance and what it pays for; and
- Study and make health care for patients better.

The choice you make does NOT let health insurers see your information to decide whether to give you health insurance or pay your bills.

2. **Where does my health information come from?**

Your health information comes from places and people that gave your health care or health insurance in the past. These may include hospitals, doctors, drugstores, laboratories, health plans (insurance companies), the Medicaid program, and other groups that share health information. For a list of the information available in PSYCKES, visit the PSYCKES website at www.psyckes.org and see "About PSYCKES" or ask your treatment provider to print the list for you.

3. **What laws and rules cover how my health information can be shared?**

These laws and regulations include New York Mental Hygiene Law Section 33.13, New York Public Health Law Article 27-F, and federal confidentiality rules, including 42 CFR Part 2 and 45 CFR Parts 160 and 164 (which are the rules referred to as "HIPAA").

4. **If I agree, who can get and see my information?**

The only people who can see your health information are those who you agree can get and see it, like doctors and other people who work for the SPOA and who are involved in your health care and people who work for a SPOA provider who is giving you care to help them check your health insurance or to study and make health care better for all patients.

5. **What if a person uses my information and I didn't agree to let them use it?**

If you think a person used your information, and you did not agree to give the person your information, call one of the providers you have said can see your records, the SPOA at ____________________, the United States Attorney's Office at (212) 637-2800, or the NYS Office of Mental Health Customer Relations at 800-597-8481.

6. **How long does my consent last?**

Your consent will last until the day you take back your consent, or if the SPOA stops working, or three years after the last date of service from the SPOA, whichever comes first.

7. **What if I change my mind later and want to take back my consent?**

You can take back your consent at any time by signing a Withdrawal of Consent Form and giving it to the SPOA. You can get this form by calling ______________________________. Note: Even if you later decide to take back your consent, providers who already have your information do not have to take it out of their records.

8. **How do I get a copy of this form?**

You can have a copy of this form after you sign it.