Ontario-Seneca Adult SPOA
609 West Washington St.
Geneva, NY 14456
315-789-0550 FAX: 315-789-0555
Adultspoa@lakeviewhs.org

To whom it may concern:

Thank you for your interest in connecting to services through Ontario and Seneca County's Single Point of Access (SPOA) program. SPOA offers connections to a variety of services that can support members of the community. Below is a brief description of SPOA services:

- **Community Residence (Ontario Only):** (Lakeview Health Services) This rehabilitative program is a homelike setting for individuals seeking daily guidance and support while learning to manage a mental illness. Staff is on site 24 hours. The community residence program is temporary housing, with time-limited lengths of stay.

- **Licensed Apartment Program (Ontario and Seneca):** (Lakeview Health Services) These are smaller, individual apartment settings. Staff are available to assist residents during day and evening hours and are also available by phone during nighttime hours for emergency purposes. Residents work on rehabilitation plans to develop skills to live more independently. The licensed apartment program is temporary housing, with time-limited lengths of stay.

- **Supportive Housing (Ontario and Seneca):** (Lakeview Health Services) This program assists individuals and families in finding and maintaining independent housing in the community. A rent stipend is provided to those who are eligible for the federal Section 8 Rental Assistance program. Staff have contact with individuals on a monthly basis and offers assistance with all housing-related needs. This program is temporary housing, with a primary goal of linkage to Section 8 or long-term housing.

- **Supportive SRO Housing (Ontario Only):** (DePaul Community Services Trolley Station Apartments) This program is a type of affordable housing designed to provide stable and permanent housing for individuals. These SRO units offer private living quarters within a larger building or community, with supportive housing staff who are on site, with office hours Monday through Friday from 8 AM to 5 PM. Services include collaboration with providers and providing necessary linkage toward community integration.

- **Non-Medicaid Care Management (Ontario and Seneca):** (Lakeview Health Services) Services for those without Medicaid, with linkage to surrounding resources in the community, supporting the individual's ability to handle periods of stress that might otherwise overwhelm them. **Medicaid recipients may access Care Management services via HHUNY, rather than through the SPOA process. Please contact the SPOA Coordinator for more info as needed.**

- **Assertive Community Treatment team (ACT) (Ontario and Seneca):** (Elmira Psychiatric Center) An intensive, team-based outpatient mental health service to assist individuals who have not been successful in working with clinics and other traditional forms of treatment. The program is designed

specifically to serve those with serious mental illness and high service needs, such as high use of emergency or crisis services and acute psychiatric hospitals; severe symptomology; coexisting substance abuse disorder; and high risk of justice-system involvement. ACT provides a wide range of support including a 24/7 on-call service, psychiatric care, medication management, counseling for mental health or co-occurring substance use, housing assistance, vocational services, and case management.

Eligibility determination:

- Eligibility requirements are outlined on page three of the SPOA application.
- Eligibility is determined by accessing and reviewing mental health/medical records such as through a web-based database operated by the Office of Mental Health called PSYCKES; and/or by obtaining other mental health/medical records or completing additional screenings as needed on a case-by-case basis.
- Full PSYCKES records are not passed from the SPOA Coordinator to referred service agencies. The SPOA Coordinator will complete an eligibility summary which will document your eligibility determination to share with service agencies.
- The SPOA Coordinator will work with you and/or your referral source on developing a plan to obtain eligibility documentation for services.
- Please review the attached consents providing more information regarding the use of information from Ontario/Seneca County SPOA to determine eligibility.
- In order to determine eligibility, please sign all consents attached to this SPOA application.

If you have any questions, please feel free to reach out.

Thank you

Sincerely,

Deanna Simpson
Ontario/Seneca County SPOA Coordinator
DSimpson@lakeviewhs.org
315-789-0550
Email referrals to: adultspoa@lakeviewhs.org

NEW YORK STATE OFFICE OF MENTAL HEALTH CRITERIA FOR SEVERE AND PERSISTENT MENTAL ILLNESS (SPMI) AMONG ADULTS

To be considered an adult diagnosed with severe and persistent mental illness, **"1" below must be met, in addition to either "2, "3, or "4."**

1. **Designated Mental Illness Diagnosis.**
   The individual is 18 years of age or older and currently meets the criteria for a *DSM-IV psychiatric diagnosis* other than alcohol or drug disorders (291.xx, 292.xx, 303.xx), organic brain syndromes (290.xx, 293.xx, 294.xx), developmental disabilities (299.xx, 315.xx, 319.xx, or social conditions. ICD-CM categories and codes that do not have an equivalent in DSM-IV are also included mental illness diagnoses.

AND

2. **SSI or SSDI Enrollment due to Mental Illness**.
   The individual is currently enrolled in SSI or SSDI *due to a designated mental illness*.

OR

3. **Extended Impairment in Functioning due to Mental Illness**.
   A. Documentation that the individual has experienced *two of the following four* functional limitations *due to a designated mental illness over the past 12 months* on a continuous or intermittent basis:

   i. **Marked difficulties in self-care** (personal hygiene; diet; clothing; avoiding injuries; securing health care or complying with medical advice).
   ii. **Marked restriction of activities of daily living** (maintaining a residence; using transportation; day-to-day money management; accessing community services).
   iii. **Marked difficulties in maintaining social functioning** (establishing and maintaining social relationships; interpersonal interactions with primary partner, children, other family members, friends, neighbors; social skills; compliance with social norms; appropriate use of leisure time).
   iv. **Frequent deficiencies of concentration, persistence or pace resulting in failure to complete tasks in a timely manner in work, home, or school settings** (ability to complete tasks commonly found in work settings or in structured activities that take place in home or school settings; individuals may exhibit limitations in these areas when they repeatedly are unable to complete simple tasks within an established time period, make frequent errors in tasks, or require assistance in the completion of tasks).

OR

4. **Reliance on Psychiatric Treatment, Rehabilitation, and Supports**.
   A documented history shows that the individual at some prior time met the threshold for 3 (above), but the symptoms and/or functioning problems are currently attenuated by medication or psychiatric rehabilitation and supports. Medication refers to psychotropic medications which may control certain primary manifestations of mental disorder; e.g. hallucinations, but may or may not affect functional limitations imposed by the mental disorder. Psychiatric rehabilitation and supports refer to highly structured and supportive settings (e.g. Congregate or Apartment Treatment Programs) which may greatly reduce the demands placed on the individual and thereby, minimize overt symptoms and signs of the underlying mental disorder.

Adult SPOA Referral Packet

Services requested for (check one):

_____Ontario County **_____Seneca County**

SPOA Received Date: _____ *Received By*: _____

Programs Requested: ****Some are not available in both counties. See p. 1 for descriptions and locations.*

___ Community Residence (Ont) ___ Licensed Apartment Program ___ Independent Supportive Housing

___ Trolley Station SP SRO (Ont) ___ Non-Medicaid Care Mgmt. ___ Finger Lakes/Mid Lakes ACT Team

Client Name: _____ **DOB:** _____

Home Address: _____ **Social Security #:** _____-_____-_____

_____ **Age:** _____ **Gender identity:** _____

Telephone Number: _____ **Medicaid CIN** _____

Client's County of Origin: _____ **Email address:** _____

Referral Agency : _____ **Contact Person**: _____

Address: _____

Contact Phone #: _____ **Email:** _____

Person to Notify in Case of Emergency:

Name: _____
Address: _____
Telephone: _____
Relationship: _____

What is the client's level of acceptance for this referral?

[] Accepts [] Interested in pursuing further

[] Resistive [] Does not accept

List the specific needs/reasons for referral: _____
_____
_____
_____

Living Situation at time of referral:

[ ] Lives alone	[ ] Lives with parents	[ ] Lives with other relatives	[ ] Psychiatric Center
[ ] Homeless (street)	[ ] Lives with spouse	[ ] Assisted/supported living	[ ] Correctional Facility
[ ] Homeless (shelter)	[ ] Supervised living	[ ] Nursing home/medical setting	[ ] Other _____

Start date for current living situation: _____

Any adult history of homelessness? [ ] Yes [ ] No

Does the client need 24-hour supervision? [ ] Yes [ ] No If yes, why?_____

Previous Residential Program History_____

Current Marital Status:

[ ] Never Married [ ] Married [ ] Separated [ ] Divorced [ ] Widowed
[ ] Living with significant other/domestic partner

Custody Status of Children: (check all that apply)

[ ] No children [ ] Have children all > 18 yrs old [ ] 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

Ethnicity:

[ ] White (non-Hispanic) [ ] Latino/Hispanic [ ] Black (non-Hispanic) [ ] Native American
[ ] Asian-Asian American [ ] Pacific Islander [ ] Other or dual (specify):

Current Educational Level:

[ ] Some grade school 1-8th grade [ ] Some HS 9-12th grade, no grad [ ] GED [ ] HS Grad
[ ] Some college, but no degree [ ] College Degree
[ ] Vocational, business training [ ] No formal education [ ] Other: _____

Current Employment Status:

[ ] Employed full-time [ ] Employed part-time [ ] Not employed [ ] Training program [ ] Other:_____

Current Criminal Justice Status:

[ ] None [ ] Currently incarcerated Release date: _____
[ ] CPL 330.20 [ ] Parole [ ] Probation
[ ] Released from jail/prison in the last 30 days [ ] Pending: _____
Probation/Parole Officer name and phone number:

_____ _____

Current or Last Services (check all that apply)**:**

[ ] No prior service [ ] MH residential [ ] General hospital
[ ] State Psychiatric Center [ ] MH outpatient [ ] Care management
[ ] Emergency MH

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

Outpatient Services Current or Planned: (CHECK ALL THAT APPLY)

	Current	Planned		Current	Planned
Psychiatrist/Clinic			Health		
Alcohol/Drug Treatment			Education		
Psychiatric Day Program			Vocational Services		
OMH Housing			AA/NA		
OASAS Housing			Family Support Services		
Care Management			Respite Services		
Child Preventative Services			Adult Care/SNF		
Adult Protective Services			Psychosocial Club		
Representative Payee			Transition Management		

Current CM name/agency _____

Receives ACT: [ ] Yes [ ] No
Current AOT: [ ] Yes [ ] No **If yes, please attach copy of AOT orders**.

Mental health service utilization in past 12 months:

Mental Health Clinic (If applicable):_____
Mental Health Provider: _____ Address: _____
Phone Number:_____ _____

Mental Health Diagnoses (Please include ICD 10/DSM 5 Code with each diagnosis listed):
_____
_____
_____

Signs/Symptoms of decompensation (Please be specific):
_____
_____
_____

_____# Of Psych. ED Visits
_____# Of Inpatient Psych. Admissions _____# of days
_____ Admission to Outpatient clinical services (counseling/psychiatry)

Facilities & dates of previous psychiatric treatment and/or hospitalizations:
_____
_____
_____

Behavior/circumstances precipitating most recent hospitalization:
_____
_____
_____

Use/engagement with mental health services:

Does the client understand and accept the need for prescribed medications? [ ] Yes [ ] No

Rate client compliance with medication regime:
[ ] Independent [ ] With Prompting [ ] Needs Assistance [ ] Resistive

Rate client follow through with Mental Health Appointments:
[ ] Independent [ ] With Prompting [ ] Needs Assistance [ ] Resistive

Cognitive impairment? [ ] Yes [ ] No Explain:_____
_____

Does the client have a history of any of the following?

			If Yes, Dates
Fire setting	[ ] Yes	[ ] No	_____
Sexual offense	[ ] Yes	[ ] No	_____
Violent acts causing injury or using weapons	[ ] Yes	[ ] No	_____
Aggressive /assaultive behavior	[ ] Yes	[ ] No	_____

Suicidal ideation	[ ] Yes	[ ] No	_____
Suicide attempts/gestures	[ ] Yes	[ ] No	_____
Destruction of property	[ ] Yes	[ ] No	_____
Victim of physical abuse	[ ] Yes	[ ] No	_____
Victim of sexual abuse	[ ] Yes	[ ] No	_____

If you answered yes to any of the above, please describe the circumstances and method: _____
_____
_____

Are there any guns or weapons in the client's home? [ ] Yes [ ] No

Medical Health:

Primary Care Physician:

Physician Practice Name (If Applicable): _____
Name: _____ Address: _____
Phone Number: _____ _____

(Check all that apply)

[ ] None	[ ] Respiratory disease	[ ] Cardiovascular disease	[ ] Diabetes /metabolic
[ ] BMI over 25	[ ] HIV/AIDS	[ ] Incontinent	[ ] Impaired ability to walk
[ ] Hearing impairment	[ ] Impaired vision equipment	[ ] Special medical	[ ] Other Medical

Number of medical emergency room visits over the past 12 months: _____
Explanation of medical/emergency issues: _____
_____
_____

Known Allergies:
Medications:_____
Food:_____
Other:_____

Are there any specific Emergency Procedures/Protocols to be used by residential staff? What are they?
_____

Substance Use History:

Does the client smoke cigarettes? [ ] Yes [ ] No If yes, how much/often: _____
Does the client Vape? [ ] Yes [ ] No If yes, how much/often: _____
Does the client have a history of drug/alcohol abuse/dependency? [ ] Yes [ ] No

If yes, at what age did use begin? _____ Date of last use:_____

Drugs of Choice: (check all that apply)

[ ] None	[ ] Cocaine	[ ] Methamphetamines	[ ] Prescription drugs	[ ] Any IV drug use
[ ] Crack	[ ] PCP	[ ] Inhalant: Sniffing glue	[ ] Alcohol	[ ] Heroin/Opiates
[ ] Sedative/hypnotic	[ ] Cannabis	[ ] Hallucinogens	[ ] Benzodiazepines	[ ] Other_____

Frequency of Drug Use:

[ ] none in past month [ ] 1-3 times in past month [ ] 1-2 times/week [ ] 3-6 times/week [ ] daily

Longest period of Sobriety: _____

Chemical Dependency Treatment: [ ] Yes [ ] No

Substance Use Provider, if applicable, and contact information:

_____

If yes: Services within the past 12 months? [ ] Yes [ ] No
[ ] inpatient programs & dates:_____

[ ] outpatient programs & dates:_____

If client is currently in a chemical dependency treatment Program, anticipated discharge date? _____

Previous chemical dependency treatment:
[ ] inpatient programs & dates:_____
_____
_____

[ ] outpatient programs & dates:_____
_____
_____
_____

Other:

Any other information not covered above, that is relevant to the individual's overall treatment and well-being: (If not, please put N/A)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

FUNDING VERIFICATION FORM

	Case #	Currently Receives Y/N	Amount Receives (#)	Pending Application Submitted Y/N	Unknown
Social Security					
SSI					
SSD					
Public Assistance					
Veteran's Benefits					
Medicare					
Medicaid					
Food Stamps					
Pension					
Wages/Earned Income					
Unemployment					
Private Insurance					
Other 3rd Party Payer					
Trust Fund					
Medication Grant					

Court mandated expenses/debts (i.e., alimony, child support, student loans, utility bills). **Please list all known and amounts**:_____
_____

If Rep Payee, Name: _____ Address: _____

Agency: _____ Telephone #: _____

ADULT SINGLE POINT OF ACCESS (SPOA) SERVICES
CONSENT TO RELEASE INFORMATION

I hereby authorize the use or disclosure of my protected health information as follows:

1. Client Name: _____
   Last First Middle Initial

   Social Security Number: _____ Date of Birth: _____

2. The information that may be used or disclosed includes (check all that apply):

   ☐ Mental health records
   ☐ Alcohol/Drug records
   ☐ School or Education records
   ☐ Health records
   ☐ All of the records listed above

3. This information may be disclosed by:

   ☐ Any person or organization that possesses the information to be disclosed
   ☐ Any persons from Lakeview Health Services, Elmira Psychiatric Center, Clifton Springs Hospital & Clinic, Soldiers & Sailors Hospital, Newark-Wayne Hospital, Ontario County Mental Health, Seneca County Community Counseling Center, FLACRA, HHUNY & affiliates, DePaul Community Services.
   ☐ The following persons or organizations:

   _____ _____

4. The information may be disclosed to Ontario or Seneca County Mental Health and their contract agencies (Lakeview Health, Elmira Psychiatric Center) providing Housing or Case Management services, or other community agencies that may contribute to planning for my care.

5. The purpose of disclosure is to assist in my care and to obtain payment for my care from insurance companies, government benefit programs and others participating in the Residential or Case Management services.

6. Permission will be valid during the SPOA application and waiting list process. This permission expires upon completion of SPOA.

7. It is understood that this permission may be revoked. To revoke this permission, a written request should be made to the provider(s) listed above. Information disclosed before permission is revoked may not be retrieved. If action was taken in reliance on this permission, the person who relied on this permission may continue to use or disclose protected health information as needed to complete the work that began because this permission was given.

8. Psychiatric and chemical dependency information is protected under Federal and State Regulations governing confidentiality of protected health information and cannot be disclosed without my written authorization unless otherwise provided for in the regulations. Further release of information is prohibited by law. If the recipient is not a healthcare or medical insurance provider covered by the privacy regulations, the information indicated above could be re-disclosed. Release of HIV-related information requires additional authorization.

I am the person whose records will be used or disclosed. I understand and agree to this authorization.

_____ _____ _____
Print Name Date Signature

I am the personal representative of the person whose records will be used or disclosed. My relationship to that person is _____. I understand and agree to this authorization.

Representative_____ _____ _____
Print Name Date Signature

Witness_____ _____ _____
Print Name Date Signature

NEW YORK STATE OF OPPORTUNITY. Office of Mental Health

PSYCKES CONSENT FORM

The Psychiatric Services and Clinical Enhancement System (PSYCKES) is a web-based application maintained by the New York State (NYS) Office of Mental Health (OMH). It contains health information from the NYS Medicaid database, health information from clinical records, and information from other NYS health databases. For an updated list and more information about the NYS health databases in PSYCKES, visit www.psyckes.org and see "About PSYCKES.',

PSYCKES data includes identifying information (such as your name and date of birth), information about health services that have been paid for by Medicaid, information about your health care history (such as treatment for illnesses or injuries, test results, lists of medication you have taken), and information entered by you or your treatment provider into the PSYCKES application (such as a Safety Plan).

The health information in PSYCKES can help your provider deliver better care. In this Consent Form, you can choose whether or not to give your provider electronic access to your health information that is in PSYCKES. You can give consent or deny consent, and this form may be filled out now or at a later date. Your choice will not affect your ability to get medical care or health insurance coverage. Your choice to give or to deny consent will not be the basis for denial of health services.

If you check the "I GIVE CONSENT" box below, you are saying "Yes, this provider's staff involved in my care may get access to all of my medical information that is in PSYCKES."

If you check the "I DENY CONSENT" box below, you are saying "No, this provider may not see or be given access to my medical information through PSYCKES," THIS DOES NOT MEAN YOUR PROVIDER IS COMPLETELY BARRED FROM ACCESSING YOUR MEDICAL INFORMATION IN ANY WAY. FOR EXAMPLE, IF THE MEDICAID PROGRAM HAS A QUALITY CONCERN ABOUT YOUR HEALTHCARE, THEN UNDER FEDERAL AND STATE REGULATIONS YOUR PROVIDER MAY BE GIVEN ACCESS TO YOUR DATA TO ADDRESS THE QUALITY CONCERN. QUALITY CONCERNS HELP HEALTHCARE PROFESSIONALS DETERMINE WHETHER THE RIGHT SERVICES ARE BEING DELIEVERED AT THE RIGHT TIME TO THE RIGHT PEOPLE. THERE ARE ALSO EXCEPTIONS TO THE CONFIDENTIALITY LAWS THAT MAY PERMIT YOUR PROVIDER TO OBTAIN NECESSARY INFORMATION DIRECTLY FROM ANOTHER PROVIDER FOR TREATMENT PURPOSES UNDER STATE AND FEDERAL LAWS AND REGULATIONS.
Please carefully read the information on the back of this form before making your decision.

Your Consent Choices. You can fill out this form now or in the future. You have two choices:

O I GIVE CONSENT for this provider to access ALL of my electronic health information that is in PSYCKES in connection with providing me any health care services.

O I DENY CONSENT for this provider to access my electronic health information that is in PSYCKES; however, I understand that my provider may be able to obtain my information even without my consent for certain limited purposes if specifically authorized by state and federal laws and regulations.

Print Name of Patient	Date of Birth of Patient	Patient's Medicaid ID Number
Signature of Patient or Patient's Legal Representative	Date	
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)	
Signature of Witness	Print Name of Witness	

What county does the person reside in (check one)? O Ontario O Seneca

1. How providers can use your health information. They can use it only to:

   - Provide medical treatment, care coordination, and related services.
   - Evaluate and improve the quality of medical care.
   - Notify your treatment providers in an emergency (e.g., you go to an emergency room).

2. What information they can access. If you give consent, Ontario/Seneca SPOA can see ALL your health information in PSYCKES. This can include information from your health records, such as illnesses or injuries (for example, diabetes or a broken bone), test results (Xrays, blood tests, or screenings), assessment results, and medications. It may include care plans, safety plans, and psychiatric advanced directives you and your treatment provider develop. This information also may relate to sensitive health conditions, including but not limited to:

   - Mental health conditions
   - Genetic (inherited) diseases or tests
   - Alcohol or drug use
   - HIV/AIDS
   - Birth control and abortion (family planning)
   - Sexually transmitted diseases

3. Where the information comes from. Any of your health services paid for by Medicaid will be part of your record. So are services you received from a state-operated psychiatric center. Some, but not all information from your medical records is stored in PSYCKES, as is data you and your doctor enter. Your online record includes your health information from other NYS databases, and new databases may be added. For the current list of data sources and more information about PSYCKES, go to: www.psyckes.org and see "About PSYCKES", or ask your provider to print the list for you.

4. Who can access your information, with your consent. Ontario/Seneca SPOA's doctors and other staff involved in your care as well as health care providers who are covering or on call for Ontario/Seneca SPOA Staff members who perform the duties listed in #1 above also can access your information.

5. Improper access or use of your information. There are penalties for improper access to or use of your PSYCKES health information. If you ever suspect that someone has seen or accessed your information —and they shouldn't have — call:
   - Ontario/Seneca SPOA at 3157890550, or the
   - NYS Office of Mental Health Customer Relations at 800-597-8481.

6. Sharing of your information. Ontario/Seneca SPOA may share your health information with others only when state or federal law and regulations allow it. This is true for health information in electronic or paper form. Some state and federal laws also provide special protections and additional requirements for disclosing sensitive health information, such as HIV/AIDS, and drug and alcohol treatment.

7. Effective period. This Consent Form is in effect for 3 years after the last date you received services from Ontario/Seneca SPOA or until the day you withdraw your consent, whichever comes first.

8. Withdrawing your consent. You can withdraw your consent at any time by signing and submitting a Withdrawal of Consent Form to Ontario Seneca SPOA . You also can change your consent choices by signing a new Consent Form at any time. You can get these forms at www.psyckes.org or from your provider by calling Ontario Seneca SPOA at 3157890550. Please note, providers who get your health information through Ontario/Seneca SPOA while this Consent Form is in effect may copy or include your information in their medical records. If you withdraw your consent, they don't have to return the information or remove it from their records.

9. Copy of form. You can receive a copy of this Consent Form after you sign it.

[1] Laws and regulations include NY Mental Hygiene Law Section 33.13, NY Public Health Law Article 27- Page 212 F, and federal confidentiality rules, including 42 CFR Part 2 and 45 CFR Parts 160 and 164 (also referred to as "HIPAA").

ONTARIO-SENECA SINGLE POINT OF ACCESS MULTI-AGENCY AUTHORIZATION FORM FOR RELEASE OF MENTAL HEALTH AND SUBSTANCE ABUSE RECORDS

Patient information:
Name:
Address:
Birth date:

AGENCY(S) RECEIVING INFORMATION		
I am referring for services to the following agency(s) and consent to them obtaining clinical documentation. Choose appropriate agency(s):		
☐ Lakeview Health Services 609 West Washington Street Geneva NY 14456	☐ DePaul-Trolley Station Apartments 2464 County Road 28 Canandaigua NY 14424	☐ Elmira Psychiatric Center-Finger Lakes ACT Team 24 A Tillman St Geneva NY 14456

AGENCIES OR PROVIDERS WHO MAY RELEASE INFORMATION			
I have received treatment at the following agencies (please include all agencies where individual has received mental health treatment by checking boxes or writing in 'Other' space below):			
☐ Ontario County Mental Health 585-396-4363 (P) 585-396-4993 (F)	☐ Clifton Springs/ Canandaigua Behavioral Health 315-462-1050 (P) 315-462-0145 (F)	☐ UR Medicine Behavioral Health 585-273-5050 (P) 585-546-2799 (F)	☐ Seneca County Community Counseling 315-539-1980 (P) 315-539-1054 (F)
☐ Seneca Ontario Community Services 315-568-9412 (P) 315-568-6718 (F)	☐ Wayne Behavioral Health 315-946-5722 (P) 315-946-5726 (F)	☐ FLACRA 585-396-4190 (P)	☐ Canandaigua Lake Counseling 585-919-0014 (P) 585-393-0014 (F)
Other Agencies or Providers:			

INFORMATION TO BE RELEASED:

I hereby consent and permit the above agencies and program(s) I have designated under the Ontario/Seneca Single Point of Access program, to disclose, communicate and discuss with each other, the following information, as indicated by my initials on each designated line:

Mental Health Treatment

_____ my name and other personal identifying information; my status as a patient in mental health treatment, most recent evaluation of my service needs for mental health treatment, most recent service plan, and/or discharge plan(s) for mental health treatment, dates of and discharge status

Substance Abuse Treatment (if any)

_____ my name and other personal identifying information; my status as a patient in alcohol/substance abuse treatment, including dates of treatment and attendance; initial and subsequent evaluations of my service needs for alcohol/substance abuse treatment; summaries of alcohol/substance abuse assessment(s) or evaluation(s) results and history, service plans.

ONTARIO-SENECA SINGLE POINT OF ACCESS MULTI-AGENCY AUTHORIZATION FORM FOR RELEASE OF MENTAL HEALTH AND SUBSTANCE ABUSE RECORDS

PURPOSE OF DISCLOSURE
This information is being requested to permit the agency(s) designated to receive information necessary to complete my intake for services and supports referred through Ontario/Seneca Single Point of Access.

NOTICES
I hereby permit the use or disclosure of the above information to the Person/Organization/Facility/Program(s) identified above. I understand that: • Only the information described in this form may be used and/or disclosed as a result of this authorization • This information is confidential and protected by HIPAA (45 CFR Parts 160 and 164) federal privacy protections and the NYS Mental Hygiene Law. • I have a right to inspect and copy my own protected health information to be used and/or disclosed (in accordance with the requirements of the federal privacy protection regulations found under 45 CFR §164.524 and NYS Mental Hygiene Law §33.16. • All parties cannot further disclose any information obtained through the use of this authorization without my written permission, unless otherwise permitted by this release. • Confidentiality of alcohol or substance abuse treatment records are protected under HIPAA (45 CFR Parts 160 and 164) and federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR Part 2). • Alcohol and substance abuse treatment records cannot be disclosed without my written consent unless otherwise permitted in the above regulations. • I understand that generally the substance abuse program may not condition my treatment on whether I sign a consent form, but in certain limited circumstances I may be denied treatment if I do not sign a consent form.
Revocation • I may revoke this consent at any time, in writing. The written revocation must be provided to Ontario/Seneca SPOA Coordinator and/or representative of the program in which I am referred to. • I am aware my revocation will not be effective if the persons I have authorized to use and/or disclose my protected health information have already disclosed the records based upon my prior consent.
Duration/Expiration • Unless previously revoked, this authorization permits the disclosure of my mental health and/or substance abuse treatment records to the agency I have designated for a duration of 1 year.

_____	_____
(Signature of Patient)	(Signature of Guardian, if necessary)
_____	_____
Print name of Patient	Print name of Guardian, if necessary
_____	_____
Date	Date