State of New York

OFFICE OF MENTAL HEALTH

Residential Treatment Facility

REFERRAL MATERIAL

Applicant Information: Date Received: _____

_____ _____ _____

Last Name First Name Current Setting (Home, Hospital, etc)

Youth's Origination County: _____	Date of Birth	AGE	Sex ◯ M ◯ F
Is the Child an SSI Recipient? ◯ Yes ◯ No	Ethnicity: ☐ Black ☐ Eurasian ☐ Unknown ☐ White ☐ Native American ☐ Hispanic ☐ Other:	IQ – Full Scale	IQ Test Date	Citizenship ◯ USA ◯ Alien
9 digit Social Security # (123-45-6789)		8 digit Medicaid # (AA12345A)	

Youth's Guardian(s): INCLUDE CONTACT INFORMATION FOR PARENTS & DSS OR OTHER CASEWORKER

☐ Parent ☐ Relative ☐ DSS ☐ OCFS ☐ Family Court ☐ Other ☐ Adopted ☐ Not Adopted

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Title First Last Relationship to Child (Mom, Dad, DSS)

_____ _____

_____ _____

_____ _____

Street Address Telephone: (Area) 123-4567

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

City State ZIP County

If you checked OCFS, Family Court, or other above, please explain (restrictive placement, Juvenile Delinquent-Offender, Case Pending, etc.)

Youth's School District of Origin:

School District

CSE Contact CSE Phone: (Area) 123-4567

Referral Contact:

◯ Parent ◯ Legal Guardian ◯ Agency ◯ Self ◯ Other

Title First Last	AGENCY or SOURCE
Telephone: _____	
	Address
E-Mail Address:	City State ZIP

FOR OFFICE USE ONLY: Status: COUNTY:_____

Checklist of Supporting Materials for Pre-admission Certification Committee Review

CHECKLIST OF SUPPORTING MATERIALS: **In order to prevent delay in processing this application, please fill out the identifying data completely and submit all the required information.** ***(All materials listed below are required to determine RTF eligibility and Medicaid disability). According to the region of the PACC, please submit the following number of collated copies:*** **WESTERN REGION, 5 collated copies (1 contains original consents, 4 copies) & SPOA COVER & NARRATIVE to: Jean M. Sadowy, LMSW, Child and Family field coordinator, NYSOMH Western FO, 737 Delaware Ave., Suite 200, Buffalo, NY 14209**

☐1. **COVER "ACCESSING A RESIDENTIAL TREATMENT FACILITY via SPOA"**

☐2. **CONSENTS / RELEASE FORMS FOR:**

- **Application for an RTF review by PACC**
- **Release of information signed by parent/guardian or where appropriate, the child/youth which give the PACC permission to refer to and release information to RTF providers**
- **disability determination**
- **release of info to the committee on special education**
- **COPY OF BIRTH CERTIFICATE, HEALTH INS. CARD(S) (Back & Front)**

☐3. **REFERRAL SUMMARY**: Attached is a summary of the most salient features of the case, including examples and descriptions of behaviors that typify the youth's response to current placement. Include current information regarding performance of age-appropriate activities, interests, self-care skills, ability to relate to others, and certification by a mental health professional who is familiar with the case that the materials attached accurately reflect the youth's current level of functioning. In summary, why RTF level of care will serve the needs of the child.

☐4. **PSYCHIATRIC SUMMARY**: Attached is a copy of the most recent psychiatric examination (Date: _____) which includes a current mental status, history of prior psychiatric care and treatment, diagnostic formulation (with clear examples that substantiate clinical tenets), DSM IV/V diagnosis, prognosis, and a brief summary of past and present psychotropic medication and its effectiveness. ***A full psychiatric examination must have been performed within the last year, with an update within the past 90 days of the time of referral, verifying that the psychiatric examination accurately reflects the youth's current level of functioning. The update must be completed by the treating MD. – PACC may request an updated psychiatric under 90 days based upon the youth's current clinical status.***

☐5. **PSYCHOLOGICAL SUMMARY**: Attached is a copy of the most recent psychological assessment (Date: _____) which includes an assessment of sensory-motor functioning, mental status, prior history of psychological problems, behavioral skills and deficits, language cognition, self-help skills, social-affective functioning, intellectual functioning (including IQ), and prognosis. Where available, an assessment of psychodynamic functioning including tentative etiology and response to prior treatment efforts is attached. Where appropriate, clear descriptive examples that substantiate clinical tenets should be provided. ***The psychological examination should accurately reflect the youth's current level of functioning The full psychological examination should be signed by a licensed psychologist and performed within the past 2 – 3 years.***

☐6. **PSYCHO-SOCIAL which also includes the following:**

a) DEVELOPMENTAL HISTORY: Attached is an assessment of the youth=s developmental history which includes, where available and appropriate, an assessment of pre-, peri-, and post-natal periods, developmental milestones and problems, and problems and experiences which have interfered or may interfere with future development, peer relationships, and/or activities

b) ENVIRONMENTAL/FAMILY/SOCIAL STATUS: Attached is an assessment of family and community relationships, and where appropriate and available, characteristics of interactions with peer groups and adults, socioeconomic status, constellation of family group, emotional and health factors of the family, religious, and ethnic affiliation, current and past family problems, family=s expectations and predicted involvement in treatment. ***(An assessment of the family must have been performed within the last year)***

☐ 7. **EDUCATIONAL/VOCATIONAL SUMMARY**: Attached is an assessment of current and former school status and vocational assets/liabilities which include, where available and appropriate, intellectual or achievement test results, general classroom behavior, relationship with teachers and peers, ability to finish work, accuracy of work, use of free time, motivation, effective incentives/reinforcers *(it should be noted whether or not the applicant has been reviewed by a CSE; if so, their recommendations and at least Phase I of an* ***IEP should be attached****)*, current work skills and potential for improving or developing new skills, amenability to vocational counseling, aptitude, interests and motivation for getting involved in various job-related activities, physical abilities, skills and experience in seeking jobs. ***(An Education/Vocational summary must have been performed within the last six months.)***

☐8. **PHYSICAL STATUS**: Attached is a summary and most recent assessment (Date: _____) of the youth=s physical status. Materials include a statement of general overall health, general physical exam, dental and vision assessments, and where appropriate and available, a neurological exam, serology and hemoglobin reports, urinalysis, chest x-ray or tyne test report, nutritional assessment and any other physical findings. ***(A physical examination must have been performed within the past year, unless there is an ongoing medical problem, in which case, within 30 days of the time of referral.)***

The following is not required for PACC review but mandatory for RTF Admission if eligible

- **IMMUNIZATION RECORD**
- **SOCIAL SECURITY CARD** (copy)

Final: 02/16/2018

NEW YORK STATE OF OPPORTUNITY. | Office of Mental Health

AUTHORIZATION FOR REVIEW BY A PREADMISSION CERTIFICATION COMMITTEE FOR ELIGIBILITY DETERMINATION FOR RESIDENTIAL TREATMENT

Youth's Name (Last) (First) (M.I.)	Youth's Date of Birth
Youth's Address	
Referring Source Name	
Referring Source Address	

I, or my authorized representative, request that health information regarding the above named youth's care and treatment be released as set forth on this form. In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

- A specific authorization is required to use or disclose drug or alcohol diagnoses or treatment information or confidential HIV related information.
- I have the right to know what information about the youth has been shared, and why, when, and with whom it was shared.
- I have the right to cancel my authorization to release information by notifying the referring agency or PACC Coordinator in writing, or to withdraw from the RTF referral process any time before it is released. This will stop a PACC from sharing information after my consent has been withdrawn.
- I also understand that a Preadmission Certification Committee (PACC) may be composed of representatives from the following agencies:
  Office of Mental Health Office of Children and Family Services State Education Department Single Point of Access(SPOA)
- I authorize the release of clinical and educational information to a Preadmission Certification Committee (PACC) regarding the above named youth. I understand that a Preadmission Certification Committee will review and evaluate this information to determine the youth's eligibility for services in a Residential Treatment Facility and will maintain the confidentiality of this information. I understand that the information will be shared in written form, in meetings, by phone or by computerized data.
- I authorize a Preadmission Certification Committee to release the above information to the appropriate Residential Treatment Facility(s) to refer the youth for possible admission, which may include RTF referral outside of this region. I understand that this information will be used to evaluate the youth for possible admission to the RTF(s) and that the RTF(s) will maintain the confidentiality of this information.
- Should the PACC find the youth eligible for RTF, I authorize a Preadmission Certification Committee to release the above information to the youth's School District of Residence _____ Committee on Special Education(CSE), to request that the CSE evaluate the youth. I authorize the PACC to then obtain the CSE evaluation and written recommendations for appropriate educational services while the youth is attending a Residential Treatment Facility (SED Law Article 81 § 4005.1.d-e.) If the youth is in the hospital at the time of referral the school district of residence shall be the school district of residence at the time he or she entered the hospital.
- This consent to release information will expire: a) six months from the signed date if the youth is not admitted into an RTF or b) When the youth is discharged from an RTF. The PACC may request updated authorization to continue the referral/admission process.

This authorization must be completed by the parent/legal guardian and youth where appropriate to use/disclose protected health

AUTHORIZATION FOR REVIEW BY A PREADMISSION CERTIFICATION COMMITTEE

FOR ELIGIBILITY DETERMINATION FOR RESIDENTIAL TREATMENT

information, in accordance with State and federal laws and regulations. Information may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person.

NOTE WHERE INFORMATION ACCOMPANIES THIS DISCLOSURE FORM: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2 and HIPAA). The federal rules prohibit you from making further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2 and/or HIPAA. **A general authorization for the release of medical or other information is NOT sufficient for this purpose.** The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

_____
Signature of Youth (where appropriate and available)

_____ _____
Signature of Parent/Legal Guardian Relationship

_____ _____
Print Name Signed Date Signed

_____ _____
Signature of Witness Title

_____ _____
Print Name Signed Date Signed

_____ _____
Signature of Person Completing Form (If different from Parent/Guardian) Title

_____ _____
Print Name Signed Date Signed

FOR OMH USE ONLY

CONSENT HAS BEEN:

- ☐ Revoked in entirety
- ☐ Partially revoked as follows:
- ☐ Letter (Attach Copy)

DATE REQUEST RECEIVED:_____

OMH REPRESENTATIVE RECEIVING REQUEST:

_____
(OMH REPRESENTATIVE'S FULL NAME AND TITLE)

_____
(OMH REPRESENTATIVE FULL ADDRESS)

NEW YORK STATE OF OPPORTUNITY. | Office of Mental Health

REQUEST FOR DISABILITY DETERMINATION

Name of Youth: _____

Date of Birth: _____

This is to request that a Preadmission Certification Committee designated by the Office of Mental Health and the Department of Social Services determine whether the above named youth is disabled for the purposes of the Medical Assistance Program.

I authorize a Preadmission Certification Committee (PACC) to review and evaluate any mental health, health or educational information it has received to assess whether the above named youth is disabled. I also authorize a PACC to request clarification or obtain additional documentation necessary to confirm or verify this information to determine whether he/she is disabled.

I understand that this form is not an application or reapplication for Medical Assistance benefits, and that a PACC will be determining whether the above named youth is disabled but not whether he/she is eligible for Medical Assistance.

_____
Signature of Parent/Legal Guardian

_____ Relationship

_____
Date Signed

Revised 12/2017

SPOA & Residential Treatment Facility
REFERRAL MATERIAL

State of New York
OFFICE OF MENTAL HEALTH

SPOA COVER SHEET

To be completed and used by the SPOA when submitting an application to the RTF Case Manager

Last Name:_____ First Name:_____ DOB: _____
COUNTY: _____

☐ SPOA Supports the RTF Application. (Explain in Narrative)

☐ SPOA Does Not Support the RTF Application ; however, Parents/Guardians Requesting that RTF Eligibility be Pursued. (Explain in Narrative)

☐ Hospital ☐ Acute ☐ State

Services Received (check all that apply):

Residential

☐ RTF
☐ RTC
☐ RTC Critical Care
☐ CR
☐ Group Home
☐ FBT
☐ Therapeutic Foster Care
☐ Other _____

Outpatient Services

☐ Waiver
☐ SCM
☐ ICM
☐ ICM+
☐ Day Treatment
☐ Therapy (clinic or private)
☐ None
☐ Other _____
☐ Wraparound
☐ Care Coordination

Other Agencies Involved ☐ OMRDD ☐ OCFS ☐ OASAS

Parents were offered information about Family Support And/or how they can contact a family advocate: ☐ Yes ☐ No

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ATTACH PAGES THAT EXPLAIN, IN A NARRATIVE, THE FOLLOWING INFORMATION:

-REASON FOR THE REFERRAL
-WHY LOWER LEVELS OF CARE HAVE BEEN UNSUCCESSFUL
-EXPECTED OUTCOMES – INCLUDE DISCHARGE PLAN FOLLOWING RTF PLACEMENT
-DOES FAMILY/GUARDIAN AGREE WITH DISCHARGE DIRECTION

SPOA Coordinator Signature: _____ Date: _____

FOR OFFICE USE ONLY:

☐ Birth Cert. ☐ Health Ins. Card ☐ SS Card ☐ Cover ☐ Consents ☐ SPOA ☐ Referral Summary
☐ Psychiatric ☐ Psychological ☐ Psychosocial

State of New York
OFFICE OF MENTAL HEALTH

REFERRAL MATERIAL

REFERRAL SUMMARY

Referral Summary ◯ Yes ◯ No

SPOA Contacted: ◯ Yes ◯ No

Abstract:

SPOA & Residential Treatment Facility

State of New York
OFFICE OF MENTAL HEALTH

REFERRAL MATERIAL

PSYCHIATRIC SUMMARY

Psychiatric Evaluation Included? ◯ Yes ◯ No

Includes a Multi-Axis Diagnosis & Signed by a psychiatrist!

Psychiatric Update within the past 90 days? ◯ Yes ◯ No

Includes an Evaluation with Multi-Diagnosis & Signed by a psychiatrist!

Primary Axis 1 Diagnosis:

Axis 1: _____

Axis 2: _____

Axis 3: _____

Axis 4: _____

Axis 5: _____

Attach Supporting Documentation:

SPOA & Residential Treatment Facility

State of New York
OFFICE OF MENTAL HEALTH

REFERRAL MATERIAL

PSYCHOLOGICAL SUMMARY

Psychological Evaluation Attached: ◯ Yes ◯ No

Verbal IQ: _____

Full Scale IQ: _____

Performance IQ: _____

Psychological Evaluation Date: _____

Attach Supporting Documentation:

State of New York
OFFICE OF MENTAL HEALTH

REFERRAL MATERIAL

PSYCHOSOCIAL SUMMARY

Psychosocial Summary
Including FAMILY HISTORY and
DEVELOPMENTAL INFORMATION
Is Attached: ◯ Yes ◯ No

Attach Supporting Documentation:

State of New York
OFFICE OF MENTAL HEALTH

REFERRAL MATERIAL

EDUCATIONAL SUMMARY

Educational Summary Attached: ◯ Yes ◯ No

Youth's Individualized Educational Plan (IEP) is Attached: ◯ Yes ◯ No

Attach Supporting Documentation:

State of New York
OFFICE OF MENTAL HEALTH

REFERRAL MATERIAL

PHYSICAL STATUS

Medical Summary Attached: ◯ Yes ◯ No

Immunization Record Attached: ◯ Yes ◯ No

Attach Supporting Documentation:

MAILING INSTRUCTIONS

TO AVOID DELAYS, ALL DOCUMENTATION MUST BE SIGNED AND DATED

And the Application should include all Cover Sheets in front of the Information and be collated as follows:

Application Cover
4 Consent Forms (Youth signature should be present when clinically appropriate)
SPOA Cover Sheet (with Coordinator Signature)
SPOA Narrative
Copy of: Birth Certificate and Health Insurance Information (Back & Front), if approved Social Security Card
Referral Summary
Psychiatric Information (within 60-90 days must be signed by MD or psychiatrist)
Psychological Evaluation (within 3 years with full scale IQ)
Psychosocial Information
Education Summary with Current IEP
Physical Health Information and Immunizations
Additional Information – Supporting Documentation – [e.g. Specialized testing or evaluations, Current and past treatment plan, Current safety plan, past discharge summaries, etc.]

Once this application is complete & collated, FORWARD 5 COPIES (WITH ORIGINAL CONSENTS) to the County SPOA Coordinator for processing who will forward 5 Referrals to the RTF Specialist for review by the Western Region Pre-Admission Certification Committee (PACC)

APPLICATION SHOULD BE SENT TO THE FOLLOWING BASED ON THE YOUTH'S/GUARDIANS HOME COUNTY:

Allegany County SPOA Coordinator Allegany County Community Services 45 North Broad Street Wellsville, NY 14895 585-593-1991	Livingston County SPOA Coordinator Livingston County Mental Health 4600 Millennium Drive Geneseo, NY 14454 585-243-7250	Steuben County SPOA Coordinator Steuben County Mental Health 115 Liberty Street Bath, NY 14810 607-664-2548
Cattaraugus County SPOA Coordinator Cattaraugus Co. Dept. of Comm. Sers. 203 Lauren's Street Olean, NY 14760 716-373-8040 X 5307	Monroe County SPOA Coordinator Monroe Co. Dept. of Mental Health 1099 Jay Street, Bldg. J, Suite 201 Rochester, NY 14611 585-753-2881	Tioga County SPOA Coordinator Tioga County Mental Health 1062 State Rte. 38, P.O. Box 177 Owego, NY 13827 607-689-8161
Chautauqua Co. SPOA Coordinator Chautauqua Co. Dept. of Men. Hyg. Town of Chautauqua Mun. Bldg. 200 2 Academy Street Mayville, NY 14757 716-753-4150	Niagara Co. SPOA Coordinator Niagara County SPOA 5467 Upper Mountain Rd. Suite 200 Lockport, NY 14094 716-439-7527	Tompkins Co. SPOA Coordinator Tompkins Co. Mental Health 201 East Green Street Ithaca, NY 14850 607-274-6302
Chemung County SPOA Coordinator Children's Integrated Services 414 Davis Street, PO Box 588 Elmira, NY 14902 607-737-2472	Ontario County SPOA Coordinator Ontario Co. Mental Health 3019 Co. Complex Drive Canandaigua, NY 14424 585-393-2993	Wayne County SPOA Coordinator Wayne County Mental Health 1519 Nye Road, Suite 110 Lyons, NY 14489 315-946-5722
Erie County SPOA Coordinator Fam. Voices Network of Erie Co/SPOA 478 Main Street Buffalo, NY 14202 716-858-2192	Orleans County SPOA Coordinator Orleans County Mental Health 14014 Route 31 Albion, NY 14411 585-589-3290	Wyoming County SPOA Coordinator Wyoming County Mental Health 460 N. Main Street Warsaw, NY 14569 585-786-8871
Genesee Co. SPOA Coordinator Genesee Co. Mental Hlth. Services 5130 E. Main St., Rd. Suite 2 Batavia, NY 14020 585-344-1421 x 6667	Schuyler Co. SPOA Coordinator Schuyler Co. Mental Health Mill Creek Center 106 S. Perry Street Watkins Glen, NY 14891 607-535-8282	Yates County SPOA Coordinator Yates County Community Services 417 Liberty Street, Suite 2033 Penn Yan, NY 14527 585-721-8316
	Seneca County SPOA Coordinator Seneca County Mental Health 31 Thurber Drive Waterloo, NY 13165 315-539-1980 or 315-539-1752	

Updated: 2014 – May