GENESEE COUNTY COMMUNITY SERVICES

SPOE SPOA CCSI

5130 East Main Street Road – Suite 2
Batavia, NY 14020 – 3496
Phone: (585) 344-1421 Fax: (585) 345-3080

LYNDA BATTAGLIA, LCSW — **COMMUNITY SERVICES DIRECTOR**
MICHAEL FLEMING — **SPOE/SPOA/AOT COORDINATOR**
ROBERT RICCOBONO, LMHC — **CLINICAL SERVCIES DIRECTOR**

Thank you for your interest in referring to the Children's SPOA Committee of Genesee County. The Children's SPOA application must be completed **in full** before a meeting with the Committee can be scheduled. Please be sure to include the following documents so there is no delay in the processing of your referral.

_____1. SPOA Release of Information Form and Rights of Clients Form signed & dated by parent/guardian and witness

_____2. Seriously Emotionally Disturbed (SED) Checklist, completed by licensed professional

_____3. Child & Adolescent Needs & Strengths (CANS) Assessment, completed by certified professional

_____4. SPOA/Case Management Acuity Scale

The following items are helpful in determining which services a youth may qualify for, but are not required as part of the SPOA referral. If they are available, it is strongly recommended they be included in the referral.

_____1. Educational reports: IEP/504 Plans, attendance, grades & disciplinary reports

_____2. Psychological & Psychiatric Evaluations/Assessments

_____3. Current treatment plan for existing services

_____4. Police/legal reports

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Re: Child's Name _____ Date of Birth: _____

RELEASE OF / REQUEST FOR CONFIDENTIAL INFORMATION

I, _____ hereby give my consent for Genesee County Community Services Single Point of Accountability (SPOA) / Coordinated Children's Services Initiative (CCSI) to obtain from and / or release to authorized agencies or accredited schools any information of records, including but not necessarily limited to psychiatric, psychological, psychosocial, admission / discharge summaries, guidance / Individual Education Plan (IEP), probation, child protective, public assistance, preventive services, foster care and substance abuse material relative to my child _____.

I understand that all information will be treated as confidential and that the SPOA Committee, designated by Genesee County Community Services, will review and evaluate this information for the purpose of determining my child's eligibility for Coordinated Children's Service Initiative, Supportive Case Management, Intensive Case Management, Family Case Management, Multisystemic Therapy, Home and Community Based Services Waiver and other programs that may benefit my child /family. I am aware that recommendations for a different level of care may also be made.

I further consent to release the information gathered to one of the aforementioned programs, if deemed appropriate, for completion or the assessment and application process for that specific program. I understand the purpose of such disclosure of information is to expedite access to such services.

I also understand that I have the right to cancel my permission to access / release the information or withdraw from the SPOA / CCSI process any time before the information is released.

This consent to release information will expire twelve months after termination of SPOA/CCSI monitoring.

Parent / Guardian Signature	Relationship
Print Name Signed	Date of Authorization
Witness and Title	Date of Authorization

I hereby revoke my authorization for release of information.

Parent / Guardian Signature	Date Revoked
Witness and Title	Date Revoked

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Michael Fleming — **SPOE/SPOA/AOT Coordinator**
Robert Riccobono, LMHC — **Clinical Services Director**

GENESEE COUNTY COMMUNITY SERVICES
SINGLE POINT OF ACCOUNTABILITY
COORDINATED CHILDREN'S SERVICES INITIATIVE
RIGHTS OF CLIENTS

The Genesee County Community Services provides, a Single Point of Accountability and Coordinated Children's Service Initiative, to families in the county who have children at risk of placement outside of their home, due to severe emotional and/or behavioral problems.

As a consumer of the Genesee County Community Services Single Point of Accountability and/or Coordinated Children's Service Initiative, you are entitled by law to the following rights:

1. Coordination of systems, services and an individualized plan of service.
2. The right to take part in the planning process.
3. A full explanation of the services to be provided.
4. Voluntary participation in services except for the following:
   a. In the case of court-ordered services;
   b. When the consent of a court-appointed conservator or committee is needed;
   c. When the consent of a parent or guardian is needed for a minor;
   d. In the case of conduct, which poses a risk of physical harm to yourself or others.
5. To object to all or any part of your service plan without fear of termination from services, unless that objection is considered clinically contraindicated or endangers the safety of yourself or others.
6. Your records will be kept confidential.
7. Opportunity to request access to your records.
8. To receive care and service in a respectful, dignified manner that is appropriate to your needs and delivered in a safe, humane and skillful manner.
9. To be treated in a way which acknowledges and respects your cultural environment.
10. To privacy that will allow effective delivery of services.
11. To freedom from abuse and mistreatment by employees.

If you have a question, complaint or objection concerning services, you may seek assistance using the following procedures:

a. If you feel your service plan is inappropriate or that the service provider treated you in an unacceptable manner, you should contact the supervisor of the program where you are receiving services. The program supervisor will make a full inquiry as to your complaints, and will attempt to resolve the situation in a timely manner so that you can resume appropriate service.

b. If you are not satisfied with the response you receive from the program supervisor, then you may contact the Program Administrator.

c. If you are still unable to resolve the problem, you may contact the:
   Coordinator of SPOA/CCSI at 344-1421 x 6667
   Director of Clinical Services at 344-1421 x 6635
   Director of Community Services at 344-1421 x 6632

d. If you fail to resolve the problem through the above procedures, you may contact the Western NY Field Office of Mental Health in Buffalo, NY at (585) 885-4219 for assistance.

(Parent retains this page.)

Date Revised: 02/21

My signature verifies that I was given a copy of **Genesee County Community Services Board Single Point of Accountability Rights of Clients** information.

The purpose of this information is to ensure me of my rights as a client throughout the time I am receiving services.

Date Parent /Client Signature

(Please return this original signature page with the referral packet.)

Date Revised: 02/21

All fields in this application must be completed before it will be accepted for SPOA review. The application can be completed and returned online, however the Release of Information and Rights of Client, signed by the consumer must be sent by mail, as original signatures are needed on these documents. Supporting documentation as requested on page 1 must also accompany this application. Additionally, a completed "Child and Adolescent Needs & Strengths" Assessment must accompany this application.

Genesee County Community Services
Children's Single Point of Accountability
Coordinated Children's Services Initiative
5130 East Main St. Rd. Suite 2
Batavia, NY 14020
Ph: 585-344-1421
Fax: 585-345-3080

DATE OF REFERRAL: _____

CLIENT CONTACT INFORMATION/HOUSEHOLD COMPOSITION:

Client's First Name:	MI:	Last Name:
DOB:	Sex:	Primary Language:
Medicaid #:	SSN:	
Address:		
Parent's Email Address:		
City:	State:	Zip:
Home Phone:	Cell Phone:	

Parent/Guardian Contact:

Parent/Guardian Name(s):			Legal Custody?	Y N
Relationship to child:			Invite to meeting?	Y N
Address:				
City:	State:	Zip:		
Home Phone:	Cell Phone:	Work Phone:		

Parent/Guardian Contact:

Parent/Guardian Name(s):			Legal Custody?	Y N
Relationship to child:			Invite to meeting?	Y N
Address:				
City:	State:	Zip:		
Home Phone:	Cell Phone:	Work Phone:		

Others in household:

Name	**Relationship to Client** (sibling, step-parent, etc)

Briefly describe client's interactions with members of household (how gets along with siblings, etc.)

DEMOGRAPHICS:

What is Client's Race? (Check all that apply)

☐	White/Caucasian
☐	Black (specify if desired):
☐	American Indian or Alaskan Native (specify if desired):
☐	Hispanic (specify if desired):
☐	Asian/Pacific Islander (specify if desired):
☐	Other (please specify):

English Proficiency

☐	Excellent	☐	Good	☐	Fair	☐	Poor	☐	Does not speak English

EDUCATION:

Current Grade	
Current School District	
Current School Contact (name & phone)	

Child's educational placement (select one response)

☐	Mainstream/General Education Setting – no supports	☐	Residential school (CSE placement) – (specify):
☐	Mainstream/General Education Setting – with supports –(specify):	☐	Home Tutoring
☐	Special Education Classroom –(specify):	☐	Home Schooled
☐	Alternative Education Placement (specify):	☐	Not enrolled in school
☐	Day Treatment (specify):	☐	Other Specify:

Committee on special education classification (Check all that apply)

☐	Emotionally Disturbed	☐	Physically Disabled	☐	None
☐	Learning Disabled	☐	Other Health Impaired	☐	Other (specify):
☐	Sensory Impaired	☐	Multiply Handicapped		

SERVICE UTILIZATION

Current living situation? (Select one response)

☐	Independent Living	☐	OMH Community Residence	☐	General Hospital psychiatric inpatient – article 28
☐	2 Parent family	☐	OMH Residential Treatment Facility	☐	Private Psychiatric inpatient – Article 31
☐	1 Parent family	☐	DSS Foster Care/Cluster Care	☐	State Psychiatric inpatient
☐	2 Parent adoptive family	☐	Therapeutic Foster Care	☐	Runaway shelter
☐	1 Parent adoptive family	☐	Residential Treatment Center	☐	Homeless / streets
☐	Grandparent(s)	☐	Residential School (SED)	☐	Other Specify
☐	Other relative's home	☐	OCFS run facility		

Complete if in an out of home placement or currently hospitalized

Name of Program or Placement:		
Address:		
City:	State:	Zip:
Name & Title of Contact:	Phone:	
Date of Admission:	Date of anticipated discharge:	

SERVICE UTILIZATION CONTINUED

What is the child's current legal status?

☐	PINS Diversion	☐	Juvenile Delinquent	☐	None
☐	PINS	☐	Juvenile Offender	☐	Other Specify:
☐	Probation		Current Court Involvement?		Y N
If current Court involvement, date of next anticipated court appearance?					
Briefly describe legal involvement (who filed PINS, number of arrests in last 12 months, recent police contact, etc)					

Income or benefits currently receiving (Select all that apply)

☐	Social Security retirement, survivor's or dependent's (SSA)	☐	Private insurance, employer coverage, no fault or third party insurance
☐	Supplemental Security Income(SSI)	☐	VA / military benefits
☐	Social security Disability Income (SSDI)	☐	None
☐	Any Public assistance cash program: Family Assistance (TANF), Safety Net, Temporary Disability	☐	Unknown
☐	Medicare	☐	Other benefits:
☐	Medicaid		

Medicaid Status:

☐	Eligible/Active	☐	No Application Submitted	☐	Disapproved
☐	Application Pending	☐	Not Applicable	☐	Unknown

Services utilized within the last 12 months (Check all that apply)

☐	Outpatient MH Therapy	☐	Specialized Educational Services	☐	Community Residence
☐	Medication Management	☐	Day Treatment	☐	Residential Treatment Facility
☐	Care/Case Management	☐	After School Program	☐	State Psychiatric Facility
☐	Waiver services	☐	Youth Mentoring Program	☐	DSS Foster Care/Cluster Care
☐	DSS Preventive Services	☐	Inpatient Substance Abuse Treatment	☐	Therapeutic Foster Care
☐	DSS Parent Aid	☐	Outpatient Substance Abuse Treatment	☐	Residential Treatment Center
☐	PINS/Probation	☐	Partial Hospitalization	☐	Residential School (SED)
☐	STAR	☐	Psychiatric Hospitalization (admission)	☐	OPWDD Residential Services
☐	Family Support Services	☐	CPEP Visit (non-admit)	☐	OPWDD Community Services
☐	Parenting Classes	☐	ER – medical reason	☐	911/Police intervention
☐	Other: Specify:				

Enter information as of Referral date (Enter number only)

How many Psychiatric emergency room visits in the last 6 months?		How many Psychiatric hospital admissions in the last 6 months?		How many Psychiatric hospital admissions in the last 12 months?	
Briefly describe circumstances of most recent hospital experience (MHA, Admission, Duration, Etc.)					

CLINICAL

Therapist information

Name of Organization:			
Therapist name:			
Address:			
City:		State:	Zip:
Phone:	Fax:	Email:	

Prescriber information

Name of Organization:			
Prescriber name:			
Address:			
City:		State:	Zip:
Phone:	Fax:	Email:	

5 AXIS DIAGNOSIS

Axis I Diagnosis: clinical disorders, other conditions that may be a focus of clinical attention
(Please list all Diagnosis using code and description)

CODE	DESCRIPTION

Axis II Diagnosis: personality disorders, intellectual disabilities (if any)
(Please list all Diagnosis using code and description)

CODE	DESCRIPTION

Axis III Diagnosis: general medical conditions (if any)
(Please give full description and medical code if known)

CODE	DESCRIPTION

Axis IV Diagnosis: psychosocial and environmental problems? (Select all that apply)

☐	Problems with primary support group	☐	Occupational Problems	☐	Problems with access to health care services
☐	Problems related to the social environment	☐	Housing problems	☐	Problems related to access with legal system / crime
☐	Educational problems	☐	Economic problems	☐	Other (Specify):

CLINICAL CONTINUED

Does the child currently have medication prescribed for a psychiatric condition?

☐	Yes	☐	No	☐	Unknown

Please list all medications

Medication	Total daily dose	mg	cc	Medication	Total daily dose	mg	cc
		☐	☐			☐	☐
		☐	☐			☐	☐
		☐	☐			☐	☐
		☐	☐			☐	☐

How frequently was this child a victim of sexual or physical abuse? (select one response)

☐	Never	☐	One or more times in the past 6 months but not in the past 3 months	☐	One or more times in the past month, but not in the past week	☐	Unknown
☐	Not at all in the past six months	☐	One or more times in the past 3 months, but not in the past month	☐	One or more times in the past week		

SYMPTOMS

Symptoms / Risky Behaviors

Scale: 0 – Not evident 1 – Mild 2 – Moderate 3 – Marginally Severe 4 – Severe

Current Rating: All activity that has occurred ***within the last 3 months*** **History:** A History is any activity that occurred ***greater than 3 months ago***	Current Rating	History YES	Unknown
Suicidal ideation		☐	☐
Psychotic symptoms (e.g. hallucinations)		☐	☐
Depression		☐	☐
Anxiety		☐	☐
Phobias		☐	☐
Dangerous to self		☐	☐
Dangerous to others		☐	☐
Temper tantrums		☐	☐
Sleep disorders		☐	☐
Enuresis / Encopresis		☐	☐
Physical complaints		☐	☐
Substance Abuse		☐	☐
Property Destruction		☐	☐
Developmental delays		☐	☐
Sexually inappropriate/Acting out/Aggressive		☐	☐
Verbally/Physically aggressive		☐	☐
Eating Disorder		☐	☐
Peer Interactions		☐	☐
Hyperactive		☐	☐
Impulsive		☐	☐
Self injury		☐	☐
Runaway		☐	☐
Fire Play/Fire Setting		☐	☐
Animal Cruelty		☐	☐
Stealing		☐	☐
Other specify:		☐	☐

SYMPTOMS CONTINUED

Level of Functioning: How are the areas of daily functioning listed below impacted by the child's symptoms & behaviors?

Scale: 0 – Not evident 1 – Mild 2 – Moderate 3 – Marginally severe 4 – Severe

	Rating
Self - care	
Social relationships / functioning	
Cognitive functioning / communication functioning	
Self - direction	
Motor functioning	

REFERRAL SUMMARY

Reason for referral & Current Service Needs

Please describe presenting issues and what may be helpful to improve the situation. Also, include Parent/Family perspective as well as Youth's perspective, if applicable.

Services to be discussed at SPOA (Check all that apply)

☐	Outpatient MH Services	☐	Youth Mentoring Program	☐	Parenting Classes
☐	Mobile Mental Health Eval	☐	OPWDD Community Services	☐	Family Support Services
☐	Care/Case Management	☐	Outpatient Substance Abuse Treatment	☐	DSS Preventive Services
☐	Waiver services	☐	Community Residence	☐	PINS/Probation
☐	Partial Hospitalization	☐	Residential Treatment Facility	☐	STAR
☐	Other: Specify:				

Referral Source

Name of Organization:			
Referring Person's Name:			
Address:			
City:		State:	Zip:
Phone:	Fax:	Email:	

CURRENT SERVICE PROVIDERS

Please complete for all current services and providers

Service Provided	
Organization Name	
Provider Name	
Provider Address	
Provider Phone #	
Provider Email	
Provider Fax number	

Service Provided	
Organization Name	
Provider Name	
Provider Address	
Provider Phone #	
Provider Email	
Provider Fax number	

Service Provided	
Organization Name	
Provider Name	
Provider Address	
Provider Phone #	
Provider Email	
Provider Fax number	

Service Provided	
Organization Name	
Provider Name	
Provider Address	
Provider Phone #	
Provider Email	
Provider Fax number	

Service Provided	
Organization Name	
Provider Name	
Provider Address	
Provider Phone #	
Provider Email	
Provider Fax number	

Service Provided	
Organization Name	
Provider Name	
Provider Address	
Provider Phone #	
Provider Email	
Provider Fax number	

GENESEE COUNTY COMMUNITY SERVICES
CHILD/ADOLESCENT & FAMILY SINGLE POINT OF ACCESS
ACUITY SCALE (Last 6 Months of Functioning)

Name:				**Date:**	
DOB:					
Acuity Scale Need Dimension	0	1	2	3	4
Treatment Participation Score:	Client and key supports engaged in treatment	Client and supports recently engaged in treatment	Client and supports somewhat engaged in treatment	Client and key supports tenuously engaged in treatment	Not engaged and/or recent inpatient status
History of Hospitalizations Score:	None	One episode within last 5 years	One episode within last 2 years	History of multiple hospitalizations	Hospitalized within last 6 months
Medication Status Score:	No assistance needed	Stable with some support	Occasional intervention needed	Regular/recent intervention needed	Unstable at current level
Housing Score:	Stable housing	Stable housing < 6 months	Frequent housing concerns	Unstable housing situation	Homeless
Practical Needs and Financial Stability Score:	Needs consistently met/income stable > 6 months	Client/family no assistance in last 3-6 months	Client/family requires assistance to maintain basic needs	Client/family's basic needs are only minimally met	Client/family's basic needs are consistently not met
Emotional Stability/ Boundaries Score:	Stable Emotional Environment/ Boundaries	Rare Emotional/ Boundary Issues	Occasional Emotional/ Boundary Issues	Frequent Emotional/ Boundary Issues	Chaotic Environment/ Constant Concerns
Parental/Client Substance Abuse Score:	Abstinent from drugs and alcohol	None apparent for the last three months	Occasional impairment	Frequent impairment	Frequent major impairment
Client Risk (to self or others) Score:	None apparent	No recent or apparent risk/danger	Some minor episodes of risk/danger	Occasional risk/danger	Frequent episodes of risk/danger
Parental/Client Health Management Score:	No current health concerns	History of health concerns-managed	Occasional acute concerns	Recent acute concerns	Unmanaged chronic concerns
Total Score					

Comments:_____
_____

FORM COMPLETED BY: _____ ***DATE:*** _____

AGENCY/TITLE: _____

Date revised: 2/21

Serious Emotional Disturbance Checklist for Children and Adolescents

Client Name:[Patient Full Name]	DOB:[Patient DOB]	Date Completed:[DATE]

_____ **A.** **Designated Emotional Disturbance Diagnosis:**
The youngster is less than 18 years of age and currently meets the criteria for a DSM-IV psychiatric diagnosis other than alcohol or drug disorders (291.xx, 292.xx, 303.xx, 305.xx), organic brain syndromes (290.xx, 293.xx, 294.xx), developmental disabilities (299.xx, 315.xx, 319.xx), or social conditions (Vxx.xx). ICD-9-CM categories and codes that do not have an equivalent DSM-IV are not included as designated diagnoses.

Dx Code: [DXCode] Dx Title: _____

_____ **B.** **Extended Impairment in Functioning due to Emotional Disturbance:**
(Child must meet #1)

1. The child has experienced functional limitations due to emotional disturbance over the past twelve (12) months on a continuous or intermittent basis. The functional problems must be at least moderate in at least two of the following areas or severe in at least one:
   - A. Yes_____ No_____ Self-care (personal hygiene, obtaining and eating food, dressing, avoiding injurie
   - B. Yes ____ No_____ Family Life (capacity to live in a family or family-like environment; relationships with parents or substitute parents, siblings, and other relatives; behavior in family setting).
   - C. Yes ___ No_____ Social relationships (establishing and maintaining friendships, interpersonal interactions with peers, neighbors, and other adults, social skills, compliance with social normal, play, and appropriate use of leisure time).
   - D. Yes___ No____ Self-direction/self-control (ability to sustain focused attention for long enough periods of time to permit completion of age-appropriate tasks, behavioral self-control, appropriate judgment and value systems, decision making ability).
   - E. Yes____ No_____ Learning ability (school achievement and attendance, receptive and expressive language,relationships with teachers, behavior in school).

2. Identify Global Assessment of Functioning Scale (GAF) due to emotional disturbance for the past twelve (12) months on a continuous or intermittent basis.

GAF (current):_____ **GAF (last year):_____**

_____ **C.** **Current Impairment in Functioning With Severe Symptoms**

Identify severe symptoms

_____**A.** Serious suicidal symptoms or other life-threatening, self-destructive behaviors.

_____**B.** Significant psychotic symptoms (hallucinations, delusions, bizarre behavior).

_____**C.** Behavior caused by emotional disturbances that placed the child at risk of causing personal injury or significant property damage.

SED Eligible _____ Yes _____ No

Signature & Title of person completing form Date