

NIAGARA COUNTY DEPARTMENT OF MENTAL HEALTH ASPOA PROGRAM APPLICATION

APPLICATION GUIDE

- **FOR ADULT SPOA, Pages 4 – 6 must be fully completed and submitted for review. Pages 7 - 8 are optional, but encouraged.**
 - **Page 2** ASPOA Cover Letter explaining application requirements
 - **Page 3:** ASPOA Description of Services
 - **Page 4:** ASPOA Eligibility Determination and ASPOA Service Requested
 - **Page 5:** ASPOA Combined Application
 - **Page 6** ASPOA Consent to Release & Obtain Information Form (must be completed and included with submitted application packet)
 - **Page 7 – 8:** ASPOA Family / Collateral Contact Consent Form

- **FOR RESIDENTIAL PROGRAMS:**
 - On page 4, check the agency / program(s) which are desired. The specific agency will follow up to request additional information needed in order to complete the application for residential services.

NIAGARA COUNTY DEPARTMENT OF MENTAL HEALTH ASPOA PROGRAM APPLICATION

Dear Sir/Madam and/or Referral Source,

Thank you for your interest in the Niagara County Department of Mental Health Adult Single Point of Access (ASPOA) Programs. Following this page you will find information on ASPOA criteria for referral, description of services, and application for services.

If you are the person requesting personal services and completing the application, please do your best to complete all sections. If you are uncertain of the diagnostic section, you may leave this blank, but be sure on the consent form to write in your mental health counselor's, therapist's, doctor's and/or psychiatrist's name and/or agency you attend, or have attended in the past, so we may obtain this information.

For other **referral sources**, please complete *all* applicable sections of the application (see application guide on cover of this packet). Please ensure to do all of the following:

- ❑ **Write legibly.**
- ❑ Place a **line through** or write "N/A" in spaces that are not relevant. *Do not leave lines/sections just blank.*
- ❑ **Write in all information—do not write "see attached"** as others who have authorization to review the application may not have all of the attached documentation to review.
- ❑ **Attach the following:**
 - **Supporting documentation of client's CURRENT/ MOST RECENT mental health diagnosis.** Documentation can include an initial psychiatric assessment, psychiatric progress note, treatment plan, discharge summary, etc. listing client's current / most recent diagnosis given or signed off by a psychiatrist, psychologist, psychiatric nurse practitioner, LCSW-R or LCSW. *Please only include the minimum amount of information necessary.*
 - **Signed consent forms** for all mental health treatment providers (e.g. outpatient mental health provider, any psychiatric hospitals where the client has been treated in the past year, etc) so information can be requested as appropriate to obtain necessary/additional information to determine eligibility for services. *Be sure the correct signature section is completed on the consent. Do NOT sign/witness under the section on the consent that states "Request/Authorization" to withdraw consent". That section is only utilized when a client withdraws SPOA Consent. If this section is accidentally signed, it invalidates the consent and will delay processing of the application until a valid consent is obtained.*

Please mail or fax the completed application and supporting documentation as noted above to the following:

By Mail: Niagara County Dept. of Mental Health
5467 Upper Mountain Rd. Suite 200
Lockport, NY 14094

By Fax: (716) 439-7418

- ❑ If **Residential** services (Community Residence, Apartment Program, Supported Housing) are being requested and/or recommended, submit the completed application to the SPOA program at the address / fax number listed above **and** also mail or fax a copy of the completed application to the appropriate residential agency. The residential provider will follow up with additional documentation required to complete the application.

By Mail: Community Missions, Inc.
Intake Dept.
1590 Buffalo Ave.
Niagara Falls, NY 14303
(716) 285-3403 ext 2275

Housing Options Made Easy Inc
Attn: Housing Coordinator
75 Jamestown St.
Gowanda, NY 14070
(716) 532-5508 ext 21

Living Opportunities of DePaul
Attn: Housing Coordinator
2625 Delaware Ave Suite 125
Buffalo, NY 14216
(716) 873-5253 ext 125

By Fax: (716) 285-5908

(716) 532-5618

(716) 873-8262

Should you have questions, concerns and/or would like more information, please contact us at (716) 439-7412. We are happy to assist you.

NIAGARA COUNTY DEPARTMENT OF MENTAL HEALTH ASPOA PROGRAM APPLICATION

Adult Single Point of Access (ASPOA) Description of Services

The Adult Single Point of Access (SPOA) serves Seriously and Persistently Mentally Ill (SPMI) consumers who are Niagara County residents and may have difficulty accessing housing or care management services. The Adult SPOA establishes an efficient and comprehensive single entry point for consumers into the service system while providing systems management. Consumers of services are able to enter the system more seamlessly, be served more appropriately, and gain more from the experience of being served by one or more of Niagara County's agencies. All stakeholders (consumers, Niagara County Department of Mental Health, New York State Office of Mental Health, and contract agencies) have the opportunity to view themselves as partners in a collaborative system.

The Single Point of Access (SPOA) for Adults in Niagara County is a result of the "New Initiatives Project" assigned by the New York State Office of Mental Health for County implementation. SPOA core values are:

- Incorporate NYS OMH Best Practices to improve quality and effectiveness of services.
- Assure access to services for individuals with the greatest need.
- Promote a responsible, comprehensive, and coordinated service delivery system with consumers, service providers, consumer family members, and the Niagara County Mental Health Department. Facilitate movement among the appropriate levels of service.
- Involve consumers in aspects of service planning, evaluation, and delivery and use peer support when possible.
- Ensure consumer choice

Care Management Services Provided:

Comprehensive care management; care coordination; health promotion; comprehensive transitional care, including appropriate follow up from inpatient to other settings; patient and family support; referral to community and social support services; and use of health information technology to link services.

Care management is provided to individuals with and without Medicaid coverage.

Niagara County Care Management Providers:

- Family & Children Services of Niagara, Inc.
- Horizon Health Services

Residential Services Provided:

Structured, enriching, supportive, home-like living environments that encourage independent living skills. The programs are designed to facilitate movement to the resident's permanent housing choice.

- Medication Management Training; Symptom Management Training; Daily Living Skills Training; Assertiveness Training; Community Integration; Rehabilitation Counseling; Socialization Training; and connecting to services.

Service Levels:

- **Community Missions Inc: 24 hour Supervised Treatment Community Residence** –A 10 or 12 bed structured home-like environment for clients requiring extra support or extra skills training. Some single bedrooms are available.
- **Community Missions Inc: Supportive Residential Apartment Treatment Program** - An on-site or off-site apartment environment for clients who have basic skills. Some single bedrooms and single apartments are available.
- **Community Missions Inc., Housing Options Made Easy Inc, & Living Opportunities of DePaul: Supported Housing Program** –Affordable, independent, subsidized housing that is furnished and appropriately equipped. Staff available for basic support and guidance relating to landlord relations, linkage for services, and coordination of mental health care.

Niagara County Residential Providers:

- Community Missions of Niagara Frontier, Inc.
- Housing Options Made Easy, Inc.
- Living Opportunities of DePaul

Other Services available that do not require application through SPOA:

Dale Association Geriatric Community Mental Health Nurse program: provides in-home nursing visits to SPMI adults who are 50 years of age or older and homebound. The program provides intensive intervention for six (6) to ten (10) weeks, working with consumers to link them to appropriate services and treatment in the community.

Dale Association Peer Specialist Program: provides individual, issue-specific and systems advocacy to SPMI adults ages 18 and older. The Peer Specialist is a former recipient of mental health services and has received specific training to assist peers in building the skills necessary to live independently in the community and to link with other appropriate services in the community.

Community Missions Inc. Parole Reentry Program: This program is part of the Niagara County Reentry Taskforce and serves incarcerated persons returning to the community.

NIAGARA COUNTY DEPARTMENT OF MENTAL HEALTH ASPOA PROGRAM APPLICATION

ADULT SINGLE POINT OF ACCESS (ASPOA) PROGRAM APPLICATION : For adults ages 18 and older

CLIENT NAME: _____

ELIGIBILITY DETERMINATION – please check all below that apply

In order to be eligible for services through the ASPOA Program, applicants must meet the following criteria:

- Age 18 or older**
- Be willing to participate in ASPOA Program services**
- Meet criteria for *Serious and Persistent Mental Illness (SPMI) as defined below: (Please check all that apply):**

***Seriously and Persistently Mentally Ill (SPMI) Eligibility (Must meet Criterion 1 plus 2 or 3 or 4)**

- 1.) **Currently meets criteria for a DSM Psychiatric Diagnosis** (using the most current manual) other than alcohol / drug disorders, organic brain syndromes, developmental disabilities or social conditions. ICD–CM psychiatric categories and codes that do not have an equivalent in the DSM are also included mental illness diagnoses. **AND**
- 2.) **SSI or SSDI enrollment due to a designated mental illness** **OR**
- 3.) **Experienced at least 2 of the following 4 functional limitations due to mental illness over past 12 months on a continuous or intermittent basis**
 - Self care** (personal hygiene, diet, clothing, avoiding injuries, securing health care or complying w/ medical advice)
 - Activities of daily living** (maintaining a residence, using transportation, daily money management, accessing community services)
 - Social functioning** (establishing and maintaining social relationships, interpersonal interactions with primary partner, children or other family members, friends, neighbors, social skills, compliance with social norms, appropriate use of leisure time).
 - Deficits in concentration, persistence or pace resulting in failure to complete tasks in timely manner** (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 task completion.) **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 psychotropic medication or psychiatric rehabilitation and supports (e.g. highly structured and supportive settings such as Congregate or Apartment Treatment Programs).

MOST RECENT DIAGNOSTIC INFORMATION BASED ON THE CURRENT DSM MAUNUAL

Attach supporting documentation of client's **CURRENT/ MOST RECENT** mental health diagnosis. Documentation can include an initial psychiatric assessment, psychiatric progress note, treatment plan, discharge summary, etc. listing client's current / most recent diagnosis given or signed off by a psychiatrist, doctorate level psychologist, psychiatric nurse practitioner, LCSW-R or LCSW only.

Psychiatric Diagnosis Description and include DSM code when able

Name of professional who made diagnosis (include credentials): _____

Date of Diagnosis (Please be sure to write in the most recent date of diagnosis only): _____

Client is also identified as having (please check all that apply):

- Chronic conditions, which include (check all that apply):**
 - Asthma Diabetes Heart Disease BMI > 25 Substance Use Disorder
 - Other chronic condition (specify): _____
 - HIV / AIDS (include separate consent specifying this information can be shared)
 - Risk of developing another chronic condition

ASPOA Service Requested (please check all that apply):

- Care Management** (Formerly Case Management)
- Residential -** **Community Missions Inc. 24 Hr. Supervised Community Residence (CR)**
- Community Missions Inc. Supportive Residential Apartment Treatment Program**
- Supported Housing - please check the desired agency (or agencies) of the following:**
 - Community Missions, Inc.** **Housing Options Made Easy, Inc.** **Living Opportunities of DePaul**

TYPES OF SERVICES / SUPPORT CLIENT IS IN NEED OF & NOT CURRENTLY RECEIVING

- (Check all that apply)** Individual Mental Health Therapy Day Treatment PROS Family Therapy Group Therapy
- Couples/Marital Therapy Medication Management Primary Medical Care Alcohol/Substance Abuse Treatment
- Treatment / Medication Compliance Transportation Mentoring Family Support Educational Literacy Services
- Vocational Training Employment Benefits/Entitlements Housing Social/Recreational/Community Activities
- Advocacy Crisis Intervention Coordination of services Health Promotion Daily / Independent Living Skills
- Comprehensive transitional care, including appropriate follow up from inpatient to other settings Other (please specify): _____

NIAGARA COUNTY DEPARTMENT OF MENTAL HEALTH ASPOA PROGRAM APPLICATION

CLIENT INFORMATION

For NCDMH use—client ID #				
First Name	Middle Initial	Last Name		
Social Security #	Date of Birth	Age	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender	
Current Street Address		Town	Zip	
Home Phone #	Cell Phone #	Work / Other Phone #		
Health Insurance: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Application Pending for: <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Managed Care <input type="checkbox"/> Other <i>Specify pending date of approval:</i>				
If Medicaid – provide #		Medicaid Active? <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, eligible? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
If Medicare – provide #	Other Insurance Type:		Policy Holder:	
	Policy #			
Current benefits <input type="checkbox"/> SSI <input type="checkbox"/> SSD <input type="checkbox"/> Survivor's <input type="checkbox"/> Public Assistance <input type="checkbox"/> Unemployment <input type="checkbox"/> Earned Income <input type="checkbox"/> None <input type="checkbox"/> Unknown				
Ethnicity (check all that apply) <input type="checkbox"/> White/Non-Hispanic <input type="checkbox"/> African American <input type="checkbox"/> Latino <input type="checkbox"/> Hispanic <input type="checkbox"/> Native American/Alaskan <input type="checkbox"/> Asian <input type="checkbox"/> Unknown <input type="checkbox"/> Other (<i>specify</i>):				
Brief physical description (approximate height, weight, hair / eye color, identifying features – i.e. piercings, tattoos, etc.)				
Special Needs & Preferences (physical, medical, visual, hearing, cultural/religious, language, writing, reading, developmental disability) (<i>specify</i>):				
Are services required in a language other than English? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes, specify language:</i>				
Marital Status <input type="checkbox"/> Single never married <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Unknown <input type="checkbox"/> Other (<i>specify</i>)				
Living Situation <input type="checkbox"/> Unknown <input type="checkbox"/> Alone <input type="checkbox"/> With Child(ren), # of persons in home: _____ <input type="checkbox"/> With other family / friends, # of persons in home: _____ <input type="checkbox"/> Homeless/Streets <input type="checkbox"/> Emergency Shelter <input type="checkbox"/> OMH Facility (<i>specify type</i>) <input type="checkbox"/> Hospital (<i>specify type</i>) <input type="checkbox"/> OCFS Facility (<i>specify type</i>) <input type="checkbox"/> OASAS Facility (<i>specify type</i>) <input type="checkbox"/> Jail/Correctional Facility (<i>specify current charges/ convictions and release date</i>) <input type="checkbox"/> Other (<i>specify</i>)				

Is the living environment safe? Yes No Unknown
Are there weapons in the home? Unknown No Yes *If yes, specify type:*

TREATMENT, SERVICES AND HISTORY

Services	Past 30 days Or Ongoing (√)	Past Year (√)	Prior to 1 year ago (√)	No History (√)
Psychiatric Inpatient (<i>list # of times if known</i>):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hospital Psychiatric Emergency Room, NO ADMISSION (<i>list # of times if known</i>):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emergency Mental Health / Crisis Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Health Outpatient Treatment (<i>agency / provider name & next appoint date /time</i>):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Residential Program (<i>specify</i>):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Primary Medical Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical Hospitalization (<i>list # of times if known</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol / Substance Abuse Treatment – (<i>agency</i>):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
AOT program involvement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Case / Care Management / <input type="checkbox"/> Health Home - (<i>specify</i>):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Developmental Disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Probation <input type="checkbox"/> Parole <input type="checkbox"/> Treatment Court <input type="checkbox"/> Legal involvement (<i>specify</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dept. of Social Services Protective Services - <input type="checkbox"/> Child / <input type="checkbox"/> Adult	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (<i>specify</i>):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Risk and Safety Concerns (*Check all that apply—current & history of*): suicidal ideation suicide attempts self-harm
 homicidal ideation violence/assault alcohol/substance abuse fire setting/arson Other (*specify*)

Individual identified as high risk by: Behavioral Health Organization (BHO) Health Home N/A

REFERRAL SOURCE INFORMATION

Referral Source Name (<i>Please Print</i>):	Relationship to individual:
Referral Source Signature:	
Date:	
Agency / Program:	
Complete Address and Phone Number:	

NIAGARA COUNTY DEPARTMENT OF MENTAL HEALTH ASPOA PROGRAM APPLICATION
Consent to Release & Obtain Psychiatric and/or Substance Abuse Information to / from the
Adult Single Point of Access Program (SPOA)

Please complete with appropriate signatures and forward with SPOA referral.

Client consents:

Single Point of Access Program (SPOA) is hereby granted permission to release and/or obtain information to and from the following SPOA committee representatives and any agency listed below in **Box A**:

<ul style="list-style-type: none"> • Niagara County Department of Mental Health • Niagara County Department of Social Services • Correctional Medical Care at the Niagara County Jail • Buffalo Psychiatric Center • Community Missions of Niagara Frontier, Inc. • Dale Association • Family and Children’s Services 	<ul style="list-style-type: none"> • Health Home Partners of WNY • Horizon Health Services • Housing Options Made Easy, Inc. (HOME) • Living Opportunities of DePaul • Mental Health Association • Niagara Falls Memorial Medical Center • Northpointe Council, Inc. • WNY Developmental Disabilities Regional Office • WNYIL - Independent Living of Niagara County
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I understand that the members of this committee have agreed to be bound by the highest standards defined by law (Federal 42 CFR Part 2, 45 CFR 164.524, New York State M.H.L. 33.13) to maintain the confidentiality of the information presented to the committee and to not discuss that information outside the scope of the committee.

Information in, and documentation included with or obtained for, my referral to Single Point of Access Program (SPOA) and approved to be released may contain information about my **identity, diagnosis, treatment, prognosis, and may contain information about psychiatric and/or substance abuse diagnosis**. I understand the only information disclosed will be pertinent and necessary to determine housing and care management eligibility, needs, and for assignment to one or both of those services. I further understand I have the right to attend the SPOA committee discussion regarding the appropriate level of care for my needs. The purpose or need for disclosing and obtaining information is:

- To allow the SPOA Committee to determine my eligibility, appropriate level of care, and coordinate treatment.
- To allow the SPOA Committee to assign me to care management and/or residential services.
- To allow the assigned agency to contact me and the agency or person referring me.
- To allow the SPOA Committee to complete utilization review of my progress in the assigned service(s).

I understand that it is the role of the committee to oversee the use of care management and residential services in Niagara County and to decide what level of service is most appropriate for each client in light of the demands for those services. The committee’s decision will be based on information about me. I understand that I may withdraw this permission to share information at any time without jeopardizing my current treatment or any future application for these services. Unless my permission is withdrawn I understand that this request / authorization will remain in effect as long as I continue to receive the services covered by this committee. This will allow for the periodic release of the above information as often as necessary to plan for / provide care and treatment.

CLIENT NAME:	Date of Birth:
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BOX A

Agency (Name & Address) <u>Releasing</u> / <u>Obtaining</u> Information to / from SPOA: 	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border-bottom: 1px solid black; width: 70%;"></td> <td style="border-bottom: 1px solid black; width: 30%;"></td> </tr> <tr> <td>Client Signature</td> <td align="right">Date</td> </tr> <tr> <td style="border-bottom: 1px solid black;"></td> <td></td> </tr> <tr> <td>Client’s Name Printed</td> <td></td> </tr> <tr> <td style="border-bottom: 1px solid black;"></td> <td></td> </tr> <tr> <td>Witness</td> <td align="right">Date</td> </tr> <tr> <td style="border-bottom: 1px solid black;"></td> <td></td> </tr> <tr> <td>Witness’s Name Printed</td> <td></td> </tr> </table>			Client Signature	Date			Client’s Name Printed				Witness	Date			Witness’s Name Printed	
Client Signature	Date																
Client’s Name Printed																	
Witness	Date																
Witness’s Name Printed																	

DO NOT COMPLETE BELOW THIS LINE ON THIS PAGE UNLESS CONSENT IS BEING WITHDRAWN

Request / Authorization to Withdrawal Consent:

I voluntarily withdraw my request for care management or housing services and in so doing withdraw my authorization for the Niagara County Single Point of Access Committee to continue to share information regarding me. I understand that this withdrawal does not cover actions that have already been taken by this committee.

Client’s Signature: _____ Date: _____
 Witness Signature: _____ Date: _____

NIAGARA COUNTY DEPARTMENT OF MENTAL HEALTH ASPOA PROGRAM APPLICATION

FAMILY / COLLATERAL CONTACT CONSENT FORM (2 pages):

AUTHORIZATION FOR RELEASE OF INFORMATION	Patient Name (Last, First, M.I.)
	Sex Date of Birth
	Facility/Agency Name: Niagara County Dept of Mental Health Adult Single Point of Access (ASPOA) Program & Committee Agency Representatives

This authorization must be completed by the patient or his/her personal representative to use/disclose protected health information (for other than treatment, payment, or health care operations purposes), in accordance with State and federal laws and regulations. A separate authorization is required to use or disclose confidential HIV related information.

PART 1: Authorization to Release Information

Description of Information to be Used/Disclosed (PLEASE CHECK AS APPROPRIATE):

- Identifying Information
 Presence in treatment/services
 Information necessary to engage in services
 Medical Information/Concerns
 Lethality/Risk Concerns
 Diagnosis/Prognosis/Progress in Treatment/Services
 Behavioral/Mental Health Information
 Substance use/abuse Information
 Legal/Criminal Justice Status
 Other (identify): _____

Purpose or Need for Information

1. This information is being requested: (PLEASE CHECK ONE)

- by the individual or his/her personal representative; or
 By Other (please describe) _____
 1. The purpose of the disclosure is (PLEASE DESCRIBE):
 Continuity of Care
 Coordination of Services
 Facilitate Referrals/Linkage with Needed Services
 Other (identify): _____

From/To: Name, Address, & Title of Person/Organization/Facility/Program Disclosing Information and To which Disclosure is to be Made

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 here.

To/From: Name, Address, & Title of Person/Organization/Facility/Program to Which this Disclosure is to be Made and which is Disclosing Information.

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 here.

Name:

Niagara County Dept. of Mental Health ASPOA Program & Assigned Care Management or Residential Agency
5467 Upper Mountain Rd. Suite 200, Lockport, NY 14094; Phone:
(716) 439-7412; Fax: (716) 439-7418

Family / Collateral Contact(s):

A. I hereby permit the use or disclosure of the above information to the Person/Organization/Facility/Program (s) identified above. I understand that:

1. Only this information may be used and/or disclosed as a result of this authorization.
2. This information is confidential and cannot legally be disclosed without my permission.
3. If this information is disclosed to someone who is not required to comply with federal privacy protection regulations, then it may be redisclosed and would no longer be protected.
4. I have the right to revoke (take back) this authorization at any time. My revocation must be in writing on the form provided to me by (**Niagara County Dept. of Mental Health**), shown below. I am aware that my revocation will not be effective if the persons I have authorized to use and/or disclose my protected health information have already taken action because of my earlier authorization.
5. I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from the New York State Office of Mental Health, nor will it affect my eligibility for benefits.
6. 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).

NIAGARA COUNTY DEPARTMENT OF MENTAL HEALTH ASPOA PROGRAM APPLICATION

Facility/Agency Name: Niagara County Dept of Mental Health Adult Single Point of Access (ASPOA) Program & Committee Agency Representatives	Patient's Name (Last, First, MI)	ID #
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B. Periodic Use/Disclosure: I hereby authorize the periodic use/disclosure of the information described above to the person/organization/facility/program identified above as often as necessary to fulfill the purpose identified above.

My authorization will expire:

When I am no longer receiving services from **Niagara County Dept. of Mental Health SPOA Program and agency assigned that is providing care management and/or residential services**

Other (specify) _____

C. Patient Signature: I certify that I authorize the use of my health information as set forth in this document.

 Signature of Patient or Personal Representative

 Date

 Patient's Name (Printed)

 Personal Representative's Name (Printed)

 Description of Personal Representative's Authority to Act for the Patient *(required if Personal Representative signs Authorization)*

D. Witness Statement/Signature: I have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the patient and/or the patient's personal representative.

WITNESSED BY: _____

Staff person's name and title

Authorization provided to: _____

Date: _____

To be Completed by Facility:

Signature of Staff Person Using/Disclosing Information : _____

Title: _____

Date Released: _____

PART 2: Revocation of Authorization to Release Information

I hereby revoke my authorization to use/disclose information indicated in Part I, to the Person/Organization/Facility/Program whose name and address is:

I hereby refuse to authorize the use/disclosure indicated in Part I, to the Person/Organization/Facility/Program whose name and address is: _____

 Signature of Patient or Personal Representative

 Date

 Patient's Name (Printed)

 Personal Representative's Name (Printed)

 Description of Personal Representative's Authority to Act for the Patient *(required if Personal Representative signs Revocation of Authorization)*