BROOME COUNTY SINGLE POINT OF ACCESS (SPOA)

REQUEST FOR ADDITIONAL SPOA SERVICES OR SITUATIONAL UPDATE

Last Name:

First Name:

Date of Birth: **Age:**

Phone:

Date:

Type of Request: (*choose all that apply)*

☐ **Situational Update –** *fill in sections that have changed & demographics*

☐ **Additional Services –** *complete the entire form*

Date of Current SPOA Referral *(if known):*

Address:

Reason for Request *(pending discharge, change in situation, etc.):*

Email:

Requested Services:

Type of Current Residence:

☐ **Community Residence**
☐ **Correctional Facility**
☐ **Couch Surfing**
☐ **Emergency Housing**
☐ **Inpatient Setting**
☐ **OCFS Placement**
☐ **Own Home/Caregiver Home**
☐ **Residential Treatment Facility**
☐ **Substance Use Facility**
☐ **Other *(specify below)***

Provide details:

MH, SUD, DD Diagnoses:

Child (5-21)

■ **Community Residence***
☐ **Community Respite**
☐ **Family Peer Support Services**
☐ **Medicaid Care Coordination** (Health Home)
☐ **Non-Medicaid Care Coordination**
■ **Residential Treatment Facility***

Adult (18+)

☐ **Assertive Community Treatment (ACT)**
☐ **Certified Apartment**
☐ **Community Residence**
☐ **Medicaid Care Coordination** (Health Home)
☐ **Non-Medicaid Care Coordination**
☐ **Supportive Housing**

**Contact the Child SPOA Coordinator for information about applying for these services: 607-778-1102 or childspoa@broomecounty.us*

Insurance Type:

Health Home Provider *(if applicable):*

Dates of CPEP Visits *(within the last year)*:

Dates of Hospitalizations *(within the last year)*:

☐ **Psychiatric** _____

☐ **Medical** _____

Current Providers/Services: *(include the number of visits in the last month for each provider)*

Describe Relationship with Service Provider(s) *(both with individual and family as applicable):*

For Child SPOA Only:

School District:	***School Placement:***	***CSE Status:***

Describe Relationship with School:

Last Name: _____ **First Name:** _____ **Date of Birth:**_____

High Risk Alerts *(check if current issue, within last 90 days)*:

☐ Caretaker Medical/Behavioral Health Issues	☐ Non-compliance - Appointments
☐ Crises – Requiring Intensive Services	☐ Non-compliance - Medication
☐ Fire Setting	☐ Self-Injurious Behaviors
☐ Homeless - *Current*	☐ Suicidal Ideation/Attempts/Threat
☐ Homicidal Ideation/Attempts/Threats	☐ Victim of Physical/Sexual Abuse or Neglect
☐ Inappropriate Sexual Behavior	☐ Violence towards Others

If checked, provide dates and a brief explanation: _____

_____

Please Indicate Responses to the Following Challenges:	**YES**	**NO**
Community Services and/or Supports – *lack of awareness, inappropriate use of, etc.*	☐	☐
Cultural Issues/Language Barriers	☐	☐
Criminal Justice – *current charges pending, probation or parole involvement, recent release from incarceration*	☐	☐
Housing – *changes in, or challenges maintaining*	☐	☐
Financial	☐	☐
Insurance – *lack of coverage, network availability, etc.*	☐	☐
Medical – *current health issues, unaddressed needs, medication issues, etc.*	☐	☐
Psychiatric Appointments - *scheduling, keeping, attending, following-up with, etc.*	☐	☐
Psychiatric Medication Management – *scheduling, co-pay, pharmacy, etc.*	☐	☐
Transportation	☐	☐
For Child SPOA Only:	**YES**	**NO**
Custody Issues – living with adults other than parents	☐	☐
School Placement - recent or anticipated change	☐	☐

Explain "YES" responses above and any barriers to overcoming identified challenges:

Comments: **Strengths and Challenges – *Why is this additional service needed?***

Name of Person Completing Form:	***Agency/Program:***
Signature:	***Date:***

SPOA Committee Recommendation(s):	**Date of SPOA Committee Meeting:**

☐ **Approved** for additional services ☐ **Not Approved** for additional services ☐ **Not Applicable** *(Situational Update)*

Explanation of Determination:

Alternative Services Recommended:

SPOA Coordinator:
Signature