APPLICATION FOR SERVICES
Westchester County Department of Community Mental Health (DCMH)
Children's Mental Health Services – Single Point of Access (SPOA)

To the Referral Source:

- Please **discuss this referral in detail with caregivers** and ask them to complete the **Family Questionnaire** below. Feel free to consult with us if you have any questions.
- Please fill out the application as **completely and accurately** as possible (do not leave any items blank). I**t is the responsibility of the referral source to submit an accurate, consistent and complete application.** Missing material may prevent or significantly delay processing of the SPOA referral.
- Completed applications will be reviewed within **5 days** of receipt of all necessary documentation.

Please send **2 COLLATED COPIES of**

a) This Application,
b) Psychiatric and/or Psychosocial Assessments completed within the last **6 months.**
c) Optional reports such **as Psychological Evaluations** and **IEPs**

To

Yolanda Cruz-Martinez, LCSW-R, Program Administrator, Children's SPOA
Westchester County DCMH, 112 East Post Road, 2nd Floor, White Plains, NY 10601
Fax: 914-995-6220 **Email**: YCM1@westchestergov.com **Office**: 914-995-7458

Dear Parent/Guardian:

This is an application for mental health care coordination and/or out-of-home care for your child. **Please read this information carefully, and talk about it with the person who is filling out this form with you.**

To help us better understand what would be most helpful, please complete the Family Questionnaire below. Feel free to use additional pages. Once you sign the consent for the SPOA committee to receive information about your child, the SPOA Coordinator will review the application, and may contact you to gather additional information. The SPOA Committee will then determine whether your child meets the eligibility requirements, and if so, which program best meets the needs of your child. You will be notified by mail once a decision is made.

In an effort to provide access to a greater array of services, SPOA is now partnering with the County's Cross-Systems Unit (CSU). **If you would like your family to be considered for such services, please initial the corresponding box on the following page.**

If you have any questions about the SPOA or the CSU referral process, please contact ***Yolanda Cruz-Martinez, LCSW-R*** **at (914) 995-7458 or email ycm1@westchestergov.com**

Please take a few minutes to think about your family's needs, and complete the questions below:
What are your child's strengths?

_____

What are your family's strengths?

_____

_____

What is your biggest concern right now?

_____

_____

What would make things better for your child and family?

_____

Do you have any additional comments?

_____

HIPAA Authorization to Disclose and Obtain Information

Dear Parent/Guardian:
Thank you for taking time to read this referral application for services in the Westchester County Children's Mental Health System. As the child's legal guardian, your consent is required in order for the SPOA Committee to receive your child's information and to communicate with your child's providers listed below.

The SPOA committee consists of representatives from Westchester County Department of Community Mental Health (DCMH), Family Ties of Westchester, Mental Health Association of Westchester (MHA), Westchester Jewish Community Services (WJCS), Abbott House, and Family Services of Westchester (FSW).

As the legal guardian of _____ (child's name), I hereby give permission for Westchester County's Children's SPOA to obtain information from and communicate with the following service providers:

Name of Referral Source _____ Program/Agency Name: _____

Mailing Address: _____

Provider Telephone Number: Email Address:

Name of Additional Service Provider _____ Program/Agency Name: _____

Mailing Address: _____

Provider Telephone Number: Email Address:

Information to be released to and discussed with the SPOA committee may include: a) this application, b) mental health assessments such as psychiatric evaluations, psycho-social reports, discharge summaries, and psychological evaluations, c) educational records such as CSE evaluations and IEPs and e) Child & Family Team (Network) plans if available.

The purpose of the SPOA Committee's communication with service providers is to determine your child's eligibility for SPOA services, and to determine which SPOA service is the best fit for your child and family's needs.

In an effort to offer potential access to a greater array of voluntary services, the SPOA Committee is now partnering with the County's Cross-Systems Unit (CSU), collaboration between DCMH Children's Mental Health, Department of Social Services, Probation and mental health providers from Westchester Jewish Community Services and Mental Health Association of Westchester. The SPOA Coordinator meets regularly with the CSU Director to explore and consider these additional services for families that are interested. If you would like your family to be considered for such services, please initial below. These programs are voluntary, and whether or not you consent to sharing info with the CSU will have no bearing on your SPOA application.

_____ **As the legal guardian, I hereby give permission for Westchester County's Cross-Systems Unit to review this SPOA application and accompanying documents from the parties specified above.**

I understand that:

- This information will not be disclosed to any other parties without my permission except as required by law.
- This authorization is for period of 90 days from date of Parent/Guardian signature.
- I have the right to revoke (take back) my consent at any time for any reason by contacting Yolanda Cruz-Martinez, LCSW-R Westchester County Department of Community Mental Health (914) 995-7458.

_____

Signature of Parent or Guardian Print Name Date

_____

Signature of Child/Adolescent Print Name Date

_____

Signature of Witness Print Name Date

APLICACIÓN PARA SERVICIOS

Departamento de Salud Mental Comunitaria del Condado de Westchester
Servicios de Salud Mental de Niños - Punto de Acceso Solo (SPOA)

Por favor incluya requerido a) esta aplicación, b) evaluación de salud mental completada dentro de seis meses, y, si está disponible, c) cualquier documentos adicionales que usted siente puede ser útiles (por ejemplo, evaluaciones psicológicas, evaluaciones de CSE, IEPs). Envíe a:

Yolanda Cruz-Martinez, Coordinadora **de** SPOA, Westchester County DCMH, 112 East Post Road, 2nd Fl, White Plains, NY 10601

*** Para colocaciones de salud mental fuera del hogar (CR, RTF) se requieren documentación y consentimientos adicionales***

Para detalles, por favor póngase en contacto con Yolanda Cruz-Martinez (CSW-R) al (914) 995-7458

Estimado padre/guardián:

Esta es una aplicación para la administración de casos de salud mental y/o el cuidado de su niño fuera de su hogar. Por favor lea cuidadosamente esta información y hable con la persona que está llenando este formulario con usted.

Los servicios de administración de casos ayudan a las familias de niños con graves problemas emocionales, sociales y de comportamiento obtener los servicios y el apoyo que necesitan para mantener a sus hijos de forma segura en la comunidad. Ya que usted es el experto en las necesidades de su niño y familia, el administrador de casos trabajará atentamente y en colaboración con usted para desarrollar un plan individualizado. El desarrollo y la supervisión de este plan, requerirá un fuerte compromiso por su parte, así como de la terapista de su hijo y otras personas involucradas.

Para ayudarnos a entender mejor lo que sería más útil, por favor complete el Cuestionario de Familia abajo. Siéntase libre de utilizar páginas adicionales. Una vez que firme el consentimiento para el Comité SPOA recibir información sobre su hijo, el Coordinador del SPOA revisará la aplicación y puede comunicarse con usted para obtener información adicional. El Comité SPOA entonces determinará si su hijo cumple con los requisitos de elegibilidad, y si así, el programa que mejor satisface las necesidades de su hijo. Se le notificará de nuestra decisión en el plazo de 5 días hábiles.

En un esfuerzo para facilitar el acceso a una mayor variedad de servicios voluntarios, SPOA ahora está asociado con la Unidad de Sistemas de Colaboración (CSU), una colaboración entre DCMH Salud Mental de Niños, Departamento de Servicios Sociales, Departamento de Libertad Condicional, y los proveedores de s(ra)-406 792.0o-2(ia)3(del Condado de Wes)82(pr)4(ovS2(d)-5(cio)-7( )-406 74(m)6(uni84-21(SPOA)-

Autorización de HIPAA para Revelar y Obtener Información

Estimado padre/guardián:

Gracias por tomar el tiempo para leer esta solicitud de remisión de servicios en el Sistema de Salud Mental para Niños del Condado de Westchester. Como guardián legal del niño, su consentimiento es necesario para el Comité SPOA recibir información de su hijo y comunicarse con los proveedores de su hijo enumerados abajo.

El Comité SPOA está integrado por representantes del Departamento de Salud Mental Comunitaria del Condado de Westchester (DCMH), Family Ties de Westchester, la Asociación de Salud Mental de Westchester (MHA), Servicios de la Comunidad Judía de Westchester (WJCS), la Casa Abbott, y los Servicios Familiares de Westchester (FSW).

Como el guardián legal de _____ (nombre del niño), yo doy permiso a el Comité SPOA de Niños del Condado de Westchester para obtener información de y comunicarse con los proveedores de servicios siguientes:

Nombre de la persona de remisión _____ Nombre del programa o agencia _____

Dirección de correo _____

Número de teléfono del proveedor _____ Dirección de correo electrónico _____

Nombre adicional de proveedor de servicios _____ Nombre del programa o agencia _____

Dirección de correo _____

Número de teléfono del proveedor _____ Dirección de correo electrónico _____

La información para ser revelada y discutido con el comité SPOA puede incluir: a) esta aplicación, b) las evaluaciones de salud mental, como evaluaciones psiquiátricas, reportes psico-sociales, resúmenes de salida, y evaluaciones psicológicas, c) archivos educativos, como evaluaciones de CSE y IEPs, d) historia de o participación corriente con el Departamento de Servicios Sociales o participación en otra sistemas y e) el plan del Equipo de Familia y Niño (Red) si está disponible.

El propósito de la comunicación de la Comité SPOA con proveedores de servicios es para determinar la elegibilidad de su hijo para servicios SPOA, y determinar qué servicio SPOA es el de mejor ajuste para las necesidades de su niño y familia.

En un esfuerzo de ofrecer el acceso potencial a una mayor variedad de servicios voluntarios, SPOA ahora está asociado con la Unidad de Sistemas de Colaboración (CSU), una colaboración entre DCMH Salud Mental de Niños, Departamento de Servicios Sociales, Departamento de Libertad Condicional, y los proveedores de salud mental del Servicios de la Comunidad Judía de Westchester (WJCS) y la Asociación de Salud Mental de Westchester (MHA). Si desea que su familia sea considerado para tales servicios, asegúrese de inicial abajo. Estos programas son voluntarios, tendrá ningún peso sobre su aplicación SPOA si o no usted da su consentimiento para compartir información con el CSU.

_____ Como el guardián legal, yo doy permiso a la Unidad de Sistemas de Colaboración del Condado de Westchester para revisar esta aplicación SPOA y a los documentos correspondientes de las partes mencionadas anteriormente.

Entiendo que:

- Esta información no será revelada a ningún otro partido, excepto cuando lo exija la ley.
- Esta autorización es para un período de 90 días desde la fecha de la firma del padre o guardián.
- Tengo el derecho a revocar mi consentimiento en cualquier momento por cualquier razón poniéndose en contacto con ***Yolanda Cruz-Martinez***, ***LCSW-R*** Departamento de Salud Mental Comunitaria del Condado de Westchester al (914) 995 7458.

Firma del padre o guardián	Escriba el nombre	Fecha
Firma del niño o adolescente	Escriba el nombre	Fecha
Firma del testigo	Escriba el nombre	Fecha

Child's Information			
Child's First Name:	Last Name:	Age	Date of Birth:
Social Security Number:	Gender: ❑ Male ❑ Female	Child's Primary Language: ❑ English ❑ Spanish ❑ Other (please specify) Is child fluent in English? ❑Yes ❑No	Caregivers' Primary Language: ❑ English ❑ Spanish ❑ Other (please specify) Is Caregiver fluent in English? ❑Yes ❑No
Race/Ethnicity: ❑ AA ❑ Asian ❑ Latino ❑ White ❑ Other (please specify)			

Family Contact Information:			
Parent/Guardian's First Name:	Last Name:	Address:	
Town/City:		City, State Zip:	County:
Email Address:	Home Phone:	Work Phone:	Cell Phone:
Has child ever been a client of Rockland Children's Psychiatric Center (inpt or outpt) OR a client of WMC inpt? ❑Yes ❑No		At what phone number would the family prefer to be contacted? ❑ Home ❑ Work ❑ Cell	

Insurance Information:

Type of health coverage

- ❑ Straight Medicaid (no HMO)
- ❑ Managed Care Medicaid
- ❑ Child Health Plus
- ❑ Private/Third Party Insurance
- ❑ No Insurance

Family Information

Who lives in the household? Please list relation to child and approximate age.

Education Information

Home School District:	Current School Name:	Current Grade:	CSE Classification Type:

What type of school placement is this child in (if known)?

❑ General Education ❑ Special Ed ❑ Day Treatment ❑ Home Instruction ❑ Other (please specify):

To what extent is the school an ACTIVE PARTNER in meeting child's needs? (0=Active, 3= Not at All)	0	1	2	3
School ABSENCES in past 30 days (0=none, 1=excused, 2=once or twice, 3=more than that)	0	1	2	3
School BEHAVIORS in past 30 days (0=none, 1=mild, 2=some, 3=severe)	0	1	2	3
School ACHIEVEMENT in past 30 days (0=good, 1= "C' average, 2=Failing a class, 3=may repeat grade	0	1	2	3

IQ and Adaptive Functioning (if available)

If test results are available, please list IQ and/or Adaptive Functioning Scores or ranges, and date administered here:

FSIQ_____, VCI _____, POI _____, WMI _____, Proc. Spd _____ Date of Eval: _____

If no test results are available, please provide your **best estimate** of child's intellectual functioning, below:

❑ Above Average ❑ Average ❑ Below Average ❑ Developmentally Delayed

DSM IV Diagnoses (please write out diagnosis)

Axis I	
1.(primary diagnosis)	2.
3.	4.
Axis II: Personality disorders, mental retardation.	
1.(primary diagnosis)	2.
Axis III: General medical conditions	
1.(primary diagnosis)	2.
Axis IV: Psychosocial and Environmental Problems.	
1.(primary)	2.
3.	4.
Axis V: Global Assessment of Functioning (GAF)	Name of Diagnosing Clinician and Date of Diagnosis

Medication Information

Please list medication(s) for psychiatric conditions	Please list medication(s) for physical conditions

Service Utilization

Please check off all services, both past **(P)** and Current **(C),** services received by this child

P	C	MH System	P	C	DSS System	P	C	JJ/Probation	P	C	Other
❑	❑	Resid Tx Facility (**RTF**)	❑	❑	Resid Tx Center (**RTC**)	❑	❑	OCFS Facility	❑	❑	Residential School
❑	❑	Psychiatric Hospital	❑	❑	Diag Receptn Cntr (DRC)	❑	❑	Probation RTC	❑	❑	Substance Abuse Tx
❑	❑	Community Residence	❑	❑	Group Home	❑	❑	JD Probation	❑	❑	Sanctuary (CV)
❑	❑	Fam Based Tx (FBT)	❑	❑	Ther Foster Care (TFC)	❑	❑	PINS Probation	❑	❑	Homeless Services
❑	❑	Psychotherapy Clinic	❑	❑	Foster Care	❑	❑	PINS Diversion	❑	❑	OPWDD (Dev Dis)
❑	❑	SPOA Services	❑	❑	CPS	❑	❑	CSU	❑	❑	Day Tx Program
❑	❑	State Psychiatric Hosp	❑	❑	Preventive Services				❑	❑	Other (please specify)

For each current provider, please list name of program, agency, and contact person below, if known:

To your best knowledge:

How many out-of-home placements has this child ***ever*** had? _____

How many hospitalizations has this child ***ever*** had? _____

In the past 12 months, how many **times** has child been hospitalized? _____

In the past 12 months, about how many **days** has child been hospitalized? _____

In the past 12 months, how many Psychiatric ER visits has this child had? _____

Primary Caregiver's Stressors and Challenges	0	1	2	3
10. Caregiver's **Legal Issues** due to Criminal Behaviors	❑	❑	❑	❑
11. **Physical/Health Issues**	❑	❑	❑	❑
12. **Mental Health Issues**	❑	❑	❑	❑
13. **Substance Use Issues**	❑	❑	❑	❑
14. **Developmental Issues**	❑	❑	❑	❑
15. **Housing Stability** in past 6 months (0=stable, 3=homelessness was/is an issue)	❑	❑	❑	❑
16. **Developmental Issues**	❑	❑	❑	❑
17. **Safety of Child** around others in household (0=safe, 1=okay, 2=questionable, 3=dangerous)	❑	❑	❑	❑
18. **Stability of Child's Significant Relationships**	❑	❑	❑	❑
19. **Housing Stability** in past 6 months (0=stable, 3=homelessness was/is an issue)	❑	❑	❑	❑
20. **Stability of Current Living Situation for Child** (0=stable, 3=child at risk of removal)	❑	❑	❑	❑
21. **Financial Hardship**	❑	❑	❑	❑

Please Explain All Scores of 2 or 3 Below:

Child/Youth's Assets and Skills	0	1	2	3
22. **Talents and Interests** identified by Child	❑	❑	❑	❑
23. **Recreational** Interests and Involvement	❑	❑	❑	❑
24. Child's **Connection to Community Life**	❑	❑	❑	❑
25. Child's **Spirituality and Religious Involvement**	❑	❑	❑	❑
26. **Child's Problem Solving Skills**	❑	❑	❑	❑
27. **Vocational Skills** (*for kids 14 and older*)	❑	❑	❑	❑
28. **Interpersonal Skills** and ability to make good friends	❑	❑	❑	❑
29. Capacity for **Realistic and Consistent Optimism**	❑	❑	❑	❑
30. Capacity to **Enjoy Successes & Manage Disappointment**	❑	❑	❑	❑

Please Explain All Scores of 2 or 3 Below:

Child/Youth's Challenges	0	1	2	3
31. **Juvenile-Justice**/Legal Issues (3=serious, at risk of out of home placement)	❑	❑	❑	❑
32. **Developmental** issues (3=MR/ASD)	❑	❑	❑	❑
33. **Medical**/Health Issues (3=life threatening)	❑	❑	❑	❑
34. **Emotional**/**Behavioral** issues	❑	❑	❑	❑
35. **Substance-Abuse** Issues (3= current addiction)	❑	❑	❑	❑
36. Impact of **Prenatal Substance Exposure** (3=perinatal withdrawal symptoms)	❑	❑	❑	❑

Please Explain All Scores of 2 or 3

Child/Youth's Trauma (0=none, 1= mild/suspected, 2=moderate/repeated, 3= severe/pervasive)	0	1	2	3
37. **Sexual** Abuse	❑	❑	❑	❑
38. **Physical** Abuse	❑	❑	❑	❑
39. **Emotional** Abuse	❑	❑	❑	❑
40. **Medical** Trauma (3=life threatening illness or procedure)	❑	❑	❑	■
41. **Natural Disaster**				

Child/Youth's Trauma (0=none, 1= mild/suspected, 2=moderate/repeated, 3= severe/pervasive)	0	1	2	3
43. Witness to **Community Violence** (3=witnessing death)	❑	❑	❑	❑
44. Witness or Victim of **Criminal Activity** (2, 3 involve harm to family or self)	❑	❑	❑	❑

Please Explain All Scores of 2 or 3 Below

Child/Youth Traumatic Stress	0	1	2	3
45. **Affect Dysregulation** (outbursts, constriction of affect, lability, rapid shifts in emotion)	❑	❑	❑	❑
46. **Re-Experiencing** (intrusive memories, nightmares, flashbacks, reenactment of trauma)	❑	❑	❑	❑
47. **Avoidance** of traumatic thoughts, feelings, situations, people	❑	❑	❑	❑
48. **Numbing** (shut down, restricted affect or capacity to feel, restricted interests, no sense of future)	❑	❑	❑	❑
49. **Dissociation** (daydreaming, blanking out, amnesia for events, detachment, personality shifts)	❑	❑	❑	❑
50. **Somatization** (vague complaints of headaches,	❑	❑	❑	❑

Please Explain All Scores of 2 or 3 Below Please Explain All Scores of 2 or 3 Below

Other Symptoms	0	1	2	3
51. **Sleep** Problems	❑	❑	❑	❑
52. **Psychosis** (hallucinations, delusions, thought disorder, bizarre behaviors)	❑	❑	❑	❑
53. **Depression**	❑	❑	❑	❑
54. **Anxiety**	❑	❑	❑	❑
55. **Attachment** Separation Issues (difficulties separating, detachment, indiscriminate attachments)	❑	❑	❑	❑

Please Explain All Scores of 2 or 3 Below Please Explain All Scores of 2 or 3 Below

Child/Youth Risky Behaviors (0=none, 1=occasional/mild, 2=moderate/repeated, 3=severe/pervasive)	0	1	2	3
56. **Sexual Aggression**	❑	❑	❑	❑
57. **Conduct Problems**	❑	❑	❑	❑
58. **Anger Control** problems	❑	❑	❑	❑
59. **Oppositional** Behavior (3=threats to harm others)	❑	❑	❑	❑
60. **Danger to Others** (3=current homicidal ideation)	❑	❑	❑	❑
61. Risk of **Running Away**	❑	❑	❑	❑
62. **Impulsivity**/Hyperactivity	❑	❑	❑	❑
63. **Suicidal Ideation**/Behavior (3=command hallucinations, current intent and plan)	❑	❑	❑	❑
64. **Self-Injurious** Behaviors (3= SIB requires medical attn)	❑	❑	❑	❑
65. **Reckless Disregard** for own Safety (fast cars, promiscuity, provoking fights)	❑	❑	❑	❑
66. **Fire Setting**	❑	❑	❑	❑
67. Poor **Judgment**/Decision Making	❑	❑	❑	❑

Please Explain All Scores of 2 or 3 Below Please Explain All Scores of 2 or 3 Below