# Children's Single Point of Access Application Part 2: Referral Application for OMH Youth ACT, CCRs, and RTFs

| Youth Applicant's Identifying Information | | | |
|---|---|---|---|
| Legal Last Name | Legal First Name | MI | Date of Birth |
| | | | |

**Directions:** To apply for Youth Assertive Community Treatment (ACT), Children's Community Residence (CCR), or Residential Treatment Facility (RTF), complete and submit the C-SPOA Part 1 and this Part 2 application to the applicant's C-SPOA of origin.

**Note:** If an update to the information provided in the application occurs within 90 days of the initial submission, updates can be provided by re-submitting the form, with updates to relevant section(s) and selecting "check this box if no information has changed" for all others.

**Section 1: Referral Type** ☐ If resubmitting within last 90 days, check this box if no information has changed.

Select the program type(s) to which the youth applicant/family is pursuing access:

☐ OMH Youth Assertive Community Treatment (ACT)

**Not available statewide. Confirm applicant resides in one of the following catchment counties:**

☐ Albany/Schenectady
☐ Bronx
☐ Brooklyn
☐ Broome
☐ Chemung/Steuben
☐ Cortland/Chenango
☐ Erie/Niagara
☐ Fulton/Montgomery
☐ Manhattan
☐ Monroe
☐ Nassau
☐ Oneida
☐ Onondaga
☐ Orange
☐ Queens
☐ Saratoga/Warren/Washington
☐ Staten Island
☐ Suffolk
☐ Westchester

☐ OMH Children's Community Residence (CCR)

☐ OMH Residential Treatment Facility (RTF)

**For OPWDD use only**: ☐ Referral for OLV Intensive Treatment Program RTF

**Section 2: Reason for Referral** ☐ If resubmitting within last 90 days, check this box if no information has changed.

What are the current symptoms which require treatment and support? Describe the frequency, intensity, duration, and risk of harm for each symptom present.

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| What are the youth applicant/family's presenting needs? How do these needs impair the youth applicant's ability to function in the home, school, and community? |
| What are youth applicant and family strengths? |
| Is the youth applicant/family currently connected to community-based services? If so, please describe the type of service(s), frequency, duration, and coordination of services. |
| What challenges have impacted the ability of home and community-based services to meet the youth applicant and their family's needs? |

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**Section 3: Education Program Information**

☐ If resubmitting within last 90 days, check this box if no information has changed.

| Home School District | School Name | Grade |
|---|---|---|
| | | |

Has a CSE determined the applicant has a Special Education Disability or Condition? ☐ Yes ☐ No ☐ Pending

If yes, please list all that apply (e.g., Learning Disability, Emotional Disturbance, Multiple Disabilities, etc.):

| Is there a current IEP or 504 Plan? ☐ No ☐ Yes, IEP ☐ Yes, 504 | Has a CSE found the applicant eligible for New York State Alternate Assessment? ☐ No ☐ Yes | Date of Last CSE meeting Date:_____ ☐ N/A |
|---|---|---|
| | | |

| CSE Contact Name | CSE Phone | CSE Email |
|---|---|---|
| | | |

**Section 4: System and Service Involvement** ☐ If resubmitting within last 90 days, check this box if no information has changed.

| System and Service Categories | Involvement | Describe Reason for Involvement and the Timeframe<br>*If additional space is needed, please attach narrative to the application.* |
|---|---|---|
| Office for People with Developmental Disabilities (OPWDD) | NY START/CSIDD connected? ☐ Yes ☐ No ☐ Unknown | (*If applicable, indicate current status of pending eligibility or referrals.*) |
| | If current involvement:<br>Contact Name _____ Title _____<br>Phone _____ Email _____ | |
| Child Protective Services (CPS) Involvement | ☐ Past ☐ Current ☐ Unknown | |
| | If current involvement:<br>Contact Name _____ Title _____<br>Phone _____ Email _____ | |
| DSS/ACS Custody | ☐ Past ☐ Current ☐ Unknown | |
| | If current involvement:<br>Contact Name _____ Title _____<br>Phone _____ Email _____ | |

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| Family Court | ☐ Past ☐ Current ☐ Unknown | |
| | If current involvement:<br>Contact Name _____ Title _____<br>Phone _____ Email _____ | |
| PINS/PINS Diversion | ☐ Past ☐ Current ☐ Unknown | |
| | If current involvement:<br>Contact Name _____ Title _____<br>Phone _____ Email _____ | |
| Probation | ☐ Past ☐ Current ☐ Unknown | |
| | If current involvement:<br>Contact Name _____ Title _____<br>Phone _____ Email _____ | |
| Criminal Court | ☐ Past ☐ Current ☐ Unknown | (*if applicable, indicate if charges pending*) |
| | If current involvement:<br>Contact Name _____ Title _____<br>Phone _____ Email _____ | |
| OCFS Division of Juvenile Justice (OCFS DJJOY Custody) | ☐ Past ☐ Current ☐ Unknown | |
| | If current involvement:<br>Contact Name _____ Title _____<br>Phone _____ Email _____ | |

**Section 5: Residential or Inpatient Service Utilization (Over the past 2 years)** If no history of residential or inpatient admission, indicate N/A. If additional space is needed, please attach narrative.
☐ If resubmitting within last 90 days, check this box if no information has changed.

| Name of Facility | Date of Admission | Date of Discharge (or Anticipated Date of Discharge) |
|---|---|---|
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**Section 6: Discharge Planning** ☐ If resubmitting within last 90 days, check this box if no information has changed.

Detail a proposed plan for discharge. Include a discharge setting and the services that may be needed. Identify potential barriers.

**Section 7: Discharge Planning Partner(s)** Identify individuals, in addition to the parent/legal custodians and guardians, to be engaged in discharge planning discussions. If there is DSS, or an ACS Case Planning Agency involvement, the case worker and supervisor must be listed as discharge planning partners.

☐ If resubmitting within last 90 days, check this box if no information has changed.

| Name | Relationship to Youth Applicant/Family | Contact Information (Email and Phone Number) |
|---|---|---|
| | | |
| | | |
| | | |

**Section 8: Primary Provider Contact For Clinical Updates.** Complete if different than referrer.

☐ If resubmitting within last 90 days, check this box if no information has changed.

| Name | Agency Name |
|---|---|
| Phone Number | Fax Number |
| Relationship to Applicant (PCP, Therapist, Etc.) | Email Address |
| Signature | Date |

**Section 9: Supporting Documentation Guidelines and Checklist** ☐ If resubmitting within last 90 days, check this box if no information has changed.

The following documentation is required to be completed and submitted with the C-SPOA Part 1 and this Part 2 application in order for the referral to be considered "complete" and processed by C-SPOA.

☐ **C-SPOA Application Part 1**
☐ **Required Consent For Release Of Information For C-SPOA** completed by parent/legal guardian
☐ **C-SPOA Application Part 2** (this form)
☐ **Verification of Serious Emotional Disturbance** completed by Licensed Behavioral Health Practitioner -OR- a psychiatric, psychosocial, or psychological evaluation which includes a SED determination

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☐ **For referrals initiated in an inpatient setting**, **a current summary of the hospitalization is required**.
The summary of the hospitalization should address: course of treatment since time of admission (including use of increased observation (e.g.,1:1 5 min. observation), intramuscular medication for agitation, aggressive, or self-injurious behavior use of restraint) response to treatment, *current* status (e.g. overall behavior on unit, ADLs), and anticipated LOS.

☐ **For referrals initiated by Youth ACT, CCR or an RTF, submit**:
- ☐ Psychosocial which includes current course of treatment and response to treatment in the program.
- ☐ Current treatment plan

**Subsection A: Required For Youth ACT Referrals Only**

☐ If resubmitting within last 90 days, check this box if no information has changed.

☐ **Any documentation to support the following ACT eligibility criteria**:

- Youth and/or family has not adequately engaged or responded to treatment in more traditional settings.
- High use of acute psychiatric hospitals (two hospitalizations within one year, or one hospitalization of 60 days or more within one year)
- High use of psychiatric emergency or crisis services
- Persistent severe major symptoms (e.g., affective, psychotic, suicidal or significant impulse control issues)
- Residing or being discharged from in an inpatient bed, residential treatment program, or in a CCR, or being deemed eligible for RTF, but clinically assessed to be able to live in a more independent setting if intensive community services are provided. This may also include current or recent involvement (within the last six months) in another child-serving system such as juvenile justice, child welfare, foster care etc. wherein mental health services were provided.
- Home environment and/or community unable to provide necessary support for developmentally appropriate growth required to adequately address mental health needs.
- Clinically assessed to be at immediate risk of requiring a more restrictive living situation (e.g., children's community residence, psychiatric hospital, or RTF) without intensive community services

**Subsection B: Required For CCR and RTF Referrals Only**

☐ If resubmitting within last 90 days, check this box if no information has changed.

☐ **Psychiatric Evaluation**

- A full psychiatric evaluation must have been performed within the past 12 months, with an update within the past 90 days of the time of referral, verifying that the psychiatric evaluation accurately reflects the youth applicant's current level of functioning.
- The psychiatric evaluation may be signed by the treating Physician, or Nurse Practitioner.
- The psychiatric evaluation should address the following:
  - Current mental status
  - History of prior psychiatric care and treatment
  - Brief summary of past and present psychotropic medication, response to medications, reasons for changes/discontinuation, effectiveness, and side effects

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- Diagnostic formulation with clear examples that substantiate clinical conceptualization
- DSM-5 diagnosis

☐ **Psychosocial Assessment**

- A psychosocial assessment must have been performed within the past 12 months.
- The psychosocial assessment must assess both youth applicant AND family and address the following:
  - Developmental History & Needs: Include pre-natal, peri-natal, and post-natal periods, developmental milestones and problems, any services and related progress, current status and needs across domains.
  - Treatment History: Indicate current and historical therapeutic interventions and response to the course of treatment. include treatment outcomes, engagement, problems with approaches, barriers to progress.
  - Family/Community History: Include family developmental/psychiatric/medical history and current status, constellation and dynamics of family members and other natural supports, past and current family problems, socioeconomic status, religious, cultural, ethnic, and other important youth and family affiliations. Note if there are visiting restrictions, loss of rights, or other special information.
  - Educational/Vocational History: Indicate current grade, academic, social, behavioral, and emotional functioning, special education needs and supports. Note employment history and vocational interests as appropriate. Note family's involvement in school/vocational interests and achievement.
  - Skills, Talents, Interests and Strengths: Describe youth applicant/family's special interests, skills/talents, recreational interests, and other assets.
  - Court involvement, if applicable: Indicate any involvement with family/criminal court, department of probation or any such mandated treatment and level of compliance. Include last court date with outcome and next court date.
  - Other co-morbid special needs: Please include any concurrent needs including substance abuse, sexual problematic behavior, etc. If applicable, be sure to include assessments indication risk to self and others, engagement in treatment and related progress.

☐ **Psychological Assessment (Required for RTF ONLY. For CCR, only required if youth has an IEP.)**

- The psychological assessment must have been performed within the last 3 years.
- The psychological assessment must be completed signed or co-signed by a Licensed Psychologist verifying that the psychological assessment accurately reflects the youth applicant's current level of functioning.
- The psychological assessment should address the following:
  - Mental status
  - Instruments used and dates of testing. Testing completed by JD/MHS licensed psychologist is acceptable. An ACTUAL copy of the testing administered should accompany the referral; it is not sufficient to reference someone's past psychological assessment in a new document without new testing.
  - Assessment of cognition (including FSIQ verbal and nonverbal/performance IQ). Standardized adaptive testing (e.g., Vineland, ABAS) is recommended if FSIQ is below 70.

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- Evaluation of language, social-affective functioning, sensory-motor functioning, and adaptive behavior (may be based on standardized testing, interview, history, and observation, as appropriate)
- Where available and appropriate, personality assessment
- Case formulation with clear descriptive examples that substantiate clinical conceptualization

☐ **Physical/Medical Exam Documentation**

- Documentation of physical exam performed within last 12 months, unless there is an ongoing physical problem, in which case a summary within 90 days of referral is required
- Physical Exam documentation must include:
  - Statement regarding youth applicant's current health & medical history
  - Indicate any allergies, chronic and/or severe needs, potential risk factors that may interact with medications
  - Test results, prescribed treatment, and response to treatment.

☐ **If youth applicant has been reviewed by a CSE, attach**:

☐ CSE recommendations

☐ The IEP or 504, if established

☐ **If high risk behavior for sexualized behavior or fire-setting have occurred in the past two years, attach a risk assessment.** Contact C-SPOA for list of acceptable risk assessments.

☐ **If chronic/severe physical/medical needs are identified**, attach any relevant information (e.g., neurological exam, serology and hemoglobin reports, urinalysis, chest x-ray or tine test report, nutritional assessment and any other physical findings.)

**IF FOUND ELIGIBLE, the following documents will be requested for admission.**

**Please indicate which of the following are currently available**

☐ **FOR CCR ONLY:** An authorization for Children's Community Residence rehabilitation services

☐ **Proof of US Residency as evidenced by:**

☐ Copy of Birth Certificate, and

☐ Copy of Social Security Card; **OR**

☐ Copy of Permanent Residency Card; **OR**

☐ Description of current U.S. residency status from Immigration Attorney

☐ **Copy of Immunization Record**

☐ **Copy of Health Insurance Card** (front and back)

☐ If the youth applicant is DSS/ACS involved or if in the youth is in DSS/ACS custody: Any restrictions to family contact (e.g., Order of Protection)

**Subsection C: Required For RTF Referrals only**

☐ If resubmitting within last 90 days, check this box if no information has changed.

☐ **Statewide OMH RTF Authorization Review Process Consent** completed by parent/legal guardian

☐ **Statewide Request for Medicaid Childhood Disability Determination** completed by parent/legal guardian

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**Section 10: Be advised the following additional documents may be requested in order to determine eligibility for Youth ACT, CCR or RTF.**

☐ If resubmitting within last 90 days, check this box if no information has changed.

**Please indicate which of the following are available upon request:**

☐ If the youth applicant/family is DSS/ACS-involved or if in the youth applicant is in DSS/ACS custody: Family Court Order, Permanency Plan, Psycho-social

☐ Records related to involvement in other systems of care (e.g., juvenile justice, child welfare, disability services) that provide examples of functional impairment in home and community

☐ Other clinically relevant evaluations (psychiatric, psychological, neurological, occupational therapy, chemical dependency, etc.)

☐ Discharge summaries from previous inpatient, residential and outpatient treatment providers

**Section 11: Referrer Attestation**

☐ I attest that the information in this application, accurately reflects the youth's level of functioning at the time of application.

| Referrer Signature | Date |
|---|---|
| | |

| Referrer Name | Title/ Agency |
|---|---|
| | |

**--------For C-SPOA Use Only----------**

| C-SPOA Name | Email | Phone | Date Received |
|---|---|---|---|
| | | | |

Notes regarding application (e.g. completeness, resubmission, updates).

Are less restrictive services documented to be insufficient to meet the individual's severe and persistent clinical needs? ☐ Yes ☐ No ☐ Unable to determine

Provide additional information regarding the youth applicant's utilization of less restrictive treatment and support services and C-SPOA recommendation(s). If known and applicable, include any barriers encountered by the youth/family.

| | | | |
|---|---|---|---|
| Is referral for access to Youth ACT? ☐ Yes ☐ No | Date deemed complete for Youth ACT | Does the applicant meet eligibility criteria for Youth ACT? ☐ Yes ☐ No | Date youth/guardian agreed to proceed with Youth ACT referral |
| Is referral for access to CCR? ☐ Yes ☐ No | Date deemed complete for CCR | Is the applicant appropriate for CCR per the *CCR LOC Recommendation Guide*? ☐ Yes ☐ No | Date youth/guardian agreed to proceed with CCR referral |
| Is referral for access to RTF? ☐ Yes ☐ No | Date deemed complete for RTF | Date youth/guardian agreed to proceed with referral for RTF services | Date application for RTF services submitted to OMH |
| Is referral from OPWDD for the ITP? ☐ Yes ☐ No | | | |