FRANKLIN COUNTY SINGLE POINT OF ACCESS (SPOA) CHILDREN'S SERVICES

SUBMIT COMPLETED REQUEST TO: Franklin County Community Services, 136 Broadway, Suite 5, PO Box 1337, Saranac Lake, NY 12983
kkmen@co.franklin.ny.us | Phone: (518) 891-2280 | Fax: (518) 891-2080
Attn: Kathleen Kmen, Deputy Director of Community Services

OVERVIEW

Single Point of Access (SPOA) is part of the New York State Office of Mental Health (NYSOMH) 2000-2001 initiatives designed to expand the county's existing community based mental health system and help make it a more cohesive and better coordinated system. Children and Youth Single Point of Access is a part of County Local Government Units (LGUs) that brings together cross-system partners in order to provide the right service to the right children and their families at the right time. Families are best served via one person/office to ensure that this cross-system collaboration occurs at the onset of care. In New York State, the Local Government Unit (LGU) is that point of contact through the Children and Youth SPOA. Medicaid Redesign has prompted regulation that states the same agency providing direct service of Home and Community-Based Services Medicaid Waivers for children cannot be the same agency to be the source of the referral and determine need or level of care. In ongoing effort to avoid conflict of interest and to promote a best practices approach in referring and accessing services, the LGU will be that independent entity to facilitate the majority of SPOA processes and objectives, including gatekeeping of all SPOA referrals, SPOA facilitation, data tracking, HCBS Waiver screenings and eligibility determination, and cross-system collaboration to support a family's connection to needed services.

REFERRAL PROCESS

- Complete the attached *Coordinated Children's Services Initiative* referral including parent/guardian signature and child signature (as appropriate) and return to:
  Franklin County Community Services
  Attn: Kathleen Kmen, Deputy Director
  136 Broadway, Suite 5
  PO Box 1337
  Saranac Lake, NY 12983
  or Email: kkmen@co.franklin.ny.us
- The Deputy Director reviews the referral to ensure completion and forwards it on to the associated program manager or screener for screening assignment:
  Children's Health Home Care Management: April Riley
  Wrap-Around: Lindsay Hendricks
  HCBS/SPA Services: Brandon Titus
  Home and Community Based Services Waiver: Kathleen Kmen
  Community Residence: Lindsay Hendricks
  RTC/RTF: SPOA, Franklin County Department of Social Services and/or the PACC (Pre-Admission Certification) Committee referral are involved in these referral processes.
- The screener contacts the parent(s)/guardian(s) to schedule a screening to obtain information related to the service need such as areas of functioning, past and current services, and diagnostic information (*Wrap-Around* does not require diagnostic information).
  - The screener obtains authorization from the parent(s)/guardian(s) to confirm any mental health diagnostic and other information related to eligibility. The referral includes eligibility information specific to the services.
- A completed screening is presented at the monthly SPOA committee meetings so that stakeholders can prioritize referred children for service availability based on the eligibility and need for services.
  - The committee may also assist in identifying additional services and plans for children that are not deemed eligible for SPOA services or when requested services are not immediately available.
- A child/family prioritized by the SPOA Committee to receive available services will be notified and offered the service following the SPOA Committee meeting.
  - Enrollment/admission typically occurs the beginning of the upcoming month following the SPOA meeting.
  - If no requested service is available then the screener completes monthly updates to present at the SPOA Committee meeting until services are received, service is no longer needed, or the family closes the referral.
  - The *Community Residence* has a separate admission and discharge committee to determine a child's enrollment at the *Adirondack Youth Lodge* but a CR referral must receive SPOA endorsement by the committee members.

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The Deputy Director can be contacted by email or phone (518) 891-2280 for any additional information regarding the referral process and eligibility and/or to request referrals.

<table>
<tr><td colspan="2">Child's Name:</td><td>DOB:</td><td>Date of Referral:</td></tr>
<tr><td colspan="2">Parent/Guardian's Name:</td><td>Home Phone Number:</td><td>Work Phone Number:</td></tr>
<tr><td colspan="2">Physical Address:</td><td colspan="2">Email address:</td></tr>
<tr><td>Medicaid/CIN Number:</td><td>Other Insurance Type/Number:</td><td>DOB:</td><td>Gender:
☐Male ☐Female ☐Other</td></tr>
<tr><td>Referral Source:</td><td colspan="2">Affiliation:</td><td>Phone:</td></tr>
<tr><td>Is the child in foster care/DSS custody? ☐ No ☐Yes</td><td colspan="3">Is a caregiver receiving Health Home Care Coordination? ☐No ☐Yes
If yes, what is the Medicaid/CIN Number of that caregiver?</td></tr>
</table>

Reason for referral:

The SPOA form is to be used for any child being referred to the following services:

- **Wrap-Around/CCSI Tier I**
- **Health Home Care Coordination (HHCC)*****
- **Home and Community Based Services Waiver (HCBSW)**
- **Adirondack Youth Lodge – Community Residence**
- **Residential Treatment Facility (RTF)**

See the next page for the service checklist and information regarding additional referral documentation and eligibility.

***** A child that has Medicaid can be referred directly to Health Home but may also utilize the SPOA process. Children that do not have Medicaid must utilize the SPOA process to pursue HHCC. Children with Medicaid that appear to be eligible for HHCC will be enrolled in an online portal called Medicaid Analytic Performance Portal (MAPP) so that the enrollment process can be continued if eligible.**

DDCS/SPOA and Manager Use:

Date Received by DDCS/SPOA:	DDCS/SPOA Assigned to:	Date Assigned:
Date Received by Manager:	Screener Assigned:	Date Assigned to Screener:

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SERVICES (Check all that apply)	ELIGIBILITY/DOCUMENTATION
☐ **WRAP-AROUND/CCSI TIER I** Wrap-around is a strength-based approach using a series of team meetings in which multiple systems and supports come together with the child/family to develop a plan of supportive action to address needs and goals.	Any child/family in need of an intervention action plan and willing to work with a team to identify goals and objectives can be referred for Wrap-around.
HEALTH HOME CARE COORDINATION (HHCC) Check below which HHCC applies: ☐ **HHCC Due to Two Chronic Conditions** ☐ **HHCC Due to Serious Emotional Disturbance** ☐ **HHCC Due to Complex Trauma** ☐ **HHCC Due to HIV/AIDS** A Health Home is a care management service model whereby all of an individual's caregivers communicate with one another so that all of a patient's needs are addressed in a comprehensive manner. The Health Home Care Coordinator is responsible for identifying the recipient's needs (particularly those surrounding the eligibility criteria) and developing plans of support to ensure they have access to and participate in care including medical, social, and behavioral health services.	**Medicaid members eligible to be enrolled in a Health Home must have:** ●Two or more chronic conditions (e.g. Substance Use Disorder, Asthma, Diabetes) (additional chronic conditions can be found on https://www.health.ny.gov/diseases/chronic/) **OR** ●One single qualifying condition -HIV/AIDS -Serious Emotional Disturbance (SED) -Complex trauma (Documentation verifying eligibility will be requested) Eligible members must also meet *"appropriateness"* for Health Home Does the family have a Health Home preference among: ☐ *Adirondack Health Institute,* ☐ *Children's Health Home of Upstate New York, or* ☐ *Catholic Charities of Broome County?* **NON-MEDICAID** children may be referred and receive HHCC assignment but must be approved and assigned through the Franklin County Single Point of Assess (SPOA). ***Please contact Kathleen Kmen, Deputy Director of Community Services, using the contact information on the first page of the referral for more information about eligibility criteria including "Serious Emotional Disturbance", "Complex Trauma", and "Appropriateness".***
☐ **HOME AND COMMUNITY BASED SERVICES WAIVER (HCBSW)** HCBSW is the highest level of in-home and community-based Individualized Care Coordination (ICC) and offers five additional supportive services (Intensive In-home, Crisis Response, Skill Building, Respite, and Family Support). The ICC meets with the child/family a minimum of 6 contacts per month and coordinates the additional five services pertaining to involvement/appointments with other services/systems. An individualized service plan is developed to help the child meet identified goals, obtain needs, and improve functioning.	● Serious Emotional Disturbance criteria ●Between the ages of 5 and 17 years (prior to 18th birthday) ●Demonstrates complex health/ mental health needs ●At imminent risk of admission to a psychiatric institution or continued psychiatric hospitalizations ●Service and support needs cannot be met by just one agency/system ●Are capable of being cared for in the home and/or community if services are provided ●Have a viable living environment with parents/guardians able/willing to participate HCBSW ●Can be served under the HCBSW at a cost which does not exceed that of psychiatric institutional care ●Has or is eligible to receive Medicaid and to maintain Medicaid benefits through the local DSS **Additional referral documents required:** *SPOA Universal Referral Form* and *Request for Screening HCBS Waiver; diagnostic clarification and SED form completed by licensed professional.*
☐ **COMMUNITY RESIDENCE (Adirondack Youth Lodge)** The Adirondack Youth Lodge is a 24-hour 8-bed Community Residence serving youth who have serious and persistent symptoms caused by a designated mental illness diagnosis. The program is certified by the Office of Mental Health and provides local treatment options for at-risk males and females (ages 12-18). Youth and their families are engaged in improving their relationships by being provided with intensive services both in and out of the home. Restorative interventions are tailored to meet the child "where they're at", while remaining focused on empowering their entire network of support. Some services provided are behavior support, educational/vocational support, family support, health services, and medication management.	●Has attained the age of 12 but not 18 ●Has a designated mental illness diagnosis ●Has a substantial problem in social functioning due to a serious emotional disturbance within the past year which could include problems within the family, with peers, and/or in school ●Has serious and persistent symptoms of cognitive, affective, or personality disorders ●Has a level of service need which requires multi-agency intervention and involvement **Additional documents required for SPOA Endorsement of the referral:** *Adirondack Youth Lodge Referral and Admission Packet*
☐ **RESIDENTIAL TREATMENT FACILITY (RTF)** A RTF is within the inpatient system of care that provides an extended level of care for children with serious emotional disturbance. Consideration for RTF may include the level in which the child/family has participated in or had access to less intensive services/supports to help the child function safely in home, school, and community environments.	●With Serious Emotional Disturbance(SED) - emotionally disturbed criteria met ●Between the ages of 5 and 18 ●has an I.Q. greater than 51 ●Needs cannot be met in the community or a less restrictive setting other than a hospital setting. ●Relatively stable symptomatology and, in accordance with Mental Hygiene Law, may not present a likelihood of serious harm to others, and that the RTF can reasonably be expected to improve or prevent further regression so that services will no longer be needed. **Additional documents required FOLLOWING SPOA Endorsement:** *Pre-Admission Certification Committee (PACC) Referral*

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Release Authorization to Franklin County Single Point of Access (SPOA) Committee

Child's Name:	
DOB:	Parent/Guardian Name:

Parent/Guardian: By initialing the listed "Acknowledgements" you confirm your awareness of and/or agreement to/that:

_____ **Acknowledgement:** I agree to have my child considered for one of the services listed on the SPOA Referral Form.

_____ **Acknowledgement:** I understand that with my agreement, referral to one of the above programs is channeled through Franklin County's SPOA Committee. This committee is comprised of representatives from community agencies that include but are not limited to North Star Behavioral Health Services Substance Abuse Prevention and Outpatient Programs, St. Joseph's Outpatient Programs, Residential Services, Community Connections, Department of Social Services, Phoenix Project, Department of Probation, Office for People with Development Disabilities (OPWDD), Office of Mental Health (OMH), Department of Health(DOH), Youth Advocate Program, Saranac Lake Youth Center, Franklin County Community Services, School Districts' Office of Pupil Personnel Services/CSE, School Links, St. Regis Mohawk Mental Health Services, Berkshire Farms, CVPH (Champlain Valley Physicians' Hospital-Psychiatric Unit), Mobile Integration Team, Health Homes and Care Management Agencies, Adirondack Health Institute and Catholic Charities.

_____ **Acknowledgement:** I have been informed as to the nature of the services my child has been referred to and understand participation in all programs/services is voluntary (with exception of RTC).

_____ **Acknowledgement:** I understand that the members of this committee are bound to maintain the highest standard of confidentiality defined by law (HIPPA 45 CFR Parts 160 and 164; and 42 CFR, Section 2) and are not to disclose information that identifies me, my child or my family personally, outside of the SPOA Committee process. This process may include reviewing service and support options to the family as identified during SPOA meetings.

_____ **Acknowledgement:** I understand that it is the role of the committee to oversee the use of youth case coordination, treatment, and residential services in Franklin County and to determine eligibility and appropriateness for services/availability. In making its decision, the committee will use and possibly discuss all information provided during the referral and screening process to determine priority for service as it compares to other referred and screened children presented to the SPOA committee.

_____ **Acknowledgement:** I understand that I may request that an agency which possesses my child and family's protected health information exclude or hold private specific information from the SPOA Committee consideration.

_____ **Acknowledgement:** I understand that I will be contacted by the Franklin County Deputy/Director of Community Services for HCBS Waiver referrals to determine level of care and eligibility through a screening process and that care management agencies will confirmation for Health Home Care Coordination and Community Residence. All SPOA referrals are received initially by the Deputy Director for review and then forwarded on to the appropriate program manager(s) for completion of the screening process. The Deputy Director of Community Services will complete Home and Community Based Waiver screenings. Once a referral is received, the name will be placed on a SPOA Committee agenda and completed screenings will then be presented at the SPOA Committee meeting to discuss services, availability, and slot allocation/enrollment. The Deputy Director will forward the completed referral/screening to the HCBS Waiver Individualized Care Coordinator if enrolled.

_____ **Acknowledgement:** The Franklin County Deputy/Director of Community Services may track children's placement in residential settings (ex. Community Residence and RTF) to support readiness and planning for discharge back to home/community and track this information through the SPOA process. *A separate release/consent will be obtained.*

By signing this authorization I give permission for members of the SPOA Committee to share information necessary to describe my child and family's situation, to determine the most appropriate service(s) based on our needs and desires, and that all initialed Acknowledgements above reflect my understanding and awareness of the SPOA process. I may withdraw my permission to share information (except for actions already taken at any time without jeopardizing my child's current treatment or any future applications for these services. Unless my permission is withdrawn I understand at this time that this request/authorization will remain in effect as long as I continue to receive the services covered by this committee.

Individual's Signature:	Date:
Parent/Guardian Signature:	Date:
Witness Signature:	Date:

Withdrawal of Request/Authorization:

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

Individual's Signature:	Date:
Parent/Guardian Signature:	Date:
Witness Signature:	Date: