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

Please enclose required a) this application, b) mental health assessments completed within six months, and, if available, c) any additional documents you feel might be helpful (e.g. psychological assessments, CSE evaluations, IEPs). Send to: Betsy Litt, SPOA Coordinator, Westchester County DCMH, 112 East Post Road, 2nd Floor, White Plains, NY 10601

*** For mental health out-of-home programs (CR, RTF) additional consents and documentation are required ***

For details, please contact Betsy Litt at bal4@westchestergov.com or (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.

Care Coordination services help families of children with serious emotional, social and behavioral challenges get the services and supports they need to keep their children safely in the community. Since you are the expert on the needs of your child and family, the care coordinator will work closely and collaboratively with you to develop an individualized plan. Developing and monitoring this plan will require a strong commitment from you, as well as from your child's therapist and others involved.

To help us better understand what would be most helpful, please complete 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 of our decision within 3 business days.

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

If you have any questions about the SPOA or the CSU referral process, please contact **Betsy Litt, Westchester County Department of Community Mental Health at (914) 995-7458 or email bal4@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, d) history of or current Department of Social Services or other systems involvement 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 Betsy Litt, 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

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:

At what phone number would the family prefer to be contacted? ❑ Home ❑ Work ❑ Cell ❑ Other:_____

Insurance Information:

Type of health coverage	Name of Insurance Provider	Insurance ID Number (required for Medicaid)
❑ Straight Medicaid (no HMO) ❑ Private/Third Party Insurance ❑ Managed Care Medicaid ❑ No Insurance ❑ Child Health Plus		

Child's Legal Custody Status:

❑ Parent/Guardian ❑ DSS-Neglect/Abuse ❑ DSS-Voluntary Placement ❑ JD/OCFS ❑ Other

If this child lives in an out-of-home setting, please indicate the facility's name, address, phone and primary contact.

Reason for Referral

1. Please describe what are the primary issues and needs of this child and family at this time which led to referral.

2. How might SPOA services help in meeting these needs?

Optional: If you know what type of service you want, please indicate:

❑ ICM ❑ Waiver ❑ Mobile MH ❑ Community Residence ❑ RTF

Family Information

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

Family Stressors

Please list all stressors, both past (P) and current (C) affecting child's caregivers

P	C	P=Past, C= Current	P	C	(P=Past, C=Current)
❑	❑	Domestic Violence	❑	❑	Incarceration of Caregiver
❑	❑	Substance Abuse/Alcoholism	❑	❑	Serious Medical Illness
❑	❑	Mental Illness of Caregiver	❑	❑	Homelessness
❑	❑	Financial Hardship	❑	❑	Death of Household Member
❑	❑	Other (please specify)			

Education Information

Home School District:	Current School Name:	Current Grade:	Date of Last IEP:

Is this child classified by the Committee on Special Education? ❑ No ❑ Yes (please specify) _____

What type of school placement is this child in (if known)?
❑ General Education ❑ Special Ed ❑ Day Treatment ❑ Home Instruction ❑ Other (please specify):

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

Child Characteristics

Please check all items, both past (P) and Recent (R), experienced by this child

Aggression/Violence			Suicidality			Abuse			Other Red Flags		
P	**R**		**P**	**R**		**P**	**R**		**P**	**R**	
❑	❑	Verbal Threats	❑	❑	Suicidal Ideation	❑	❑	Physical Abuse	❑	❑	Fire-setting
❑	❑	Physical Aggression	❑	❑	Suicidal Gestures/Cutting	❑	❑	Sexual Abuse	❑	❑	Cruelty to Animals
❑	❑	Injury to Others	❑	❑	Serious Suicide Attempts	❑	❑	Neglect/Emot Abuse	❑	❑	Gang Involvement

Please list all behaviors, symptoms and risk factors relevant for SPOA determination and services. Please describe any challenges this child may have with managing emotions and/or behaviors. What does it look like?

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)	❑	❑	JD Probation	❑	❑	Substance Abuse Tx
❑	❑	Community Residence	❑	❑	Group Home	❑	❑	PINS Probation	❑	❑	Sanctuary (CV)
❑	❑	Fam Based Tx (FBT)	❑	❑	Ther Foster Care (TFC)	❑	❑	PINS Diversion	❑	❑	Homeless Services
❑	❑	Psychotherapy Clinic	❑	❑	Foster Care				❑	❑	OPWDD (Dev Dis)
❑	❑	SPOA Services	❑	❑	CPS				❑	❑	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? _____

STRENGTHS & NEEDS ASSESSMENT

Please attach CANS assessment completed within 3 months OR rate the child/youth on ALL of the following items. Base your rating on discussion with family, your assessment, and any other available sources of information. Ratings should be based on current (last 30 days) functioning in all settings unless otherwise indicated. **Please base your ratings on how child would function if interventions were not in place.** Thanks.

0 = Not an issue, no action needed
1 = Could become, or was in past, problematic, need to watch/monitor
2 = Problem area, action is needed
3 = Significant problem area, action needed immediately

For all items scored 2 or 3, please explain AND explain what interventions are in place.

Problem Presentation	0	1	2	3	Explain all scores of 2 or 3
1. Psychosis/thought disorder?	❑	❑	❑	❑	
2. Problems with attention or impulse control?	❑	❑	❑	❑	
3. Depression/Anxiety?	❑	❑	❑	❑	
4. Problems following rules/oppositional behavior?	❑	❑	❑	❑	
5. Antisocial behavior?	❑	❑	❑	❑	
6. Drinking or taking drugs?	❑	❑	❑	❑	
7. Difficulty adjusting to recent or past trauma?	❑	❑	❑	❑	
8. Problems with attachment?	❑	❑	❑	❑	
9. Problems occurring in more than one setting?	❑	❑	❑	❑	
10. Problems are longstanding and persistent?	❑	❑	❑	❑	
Risk Behaviors	**0**	**1**	**2**	**3**	
12. Suicidal ideation/attempt or self-injurious behavior?	❑	❑	❑	❑	
13. Danger to others?	❑	❑	❑	❑	
14. Running away or seriously breaking curfew?	❑	❑	❑	❑	
15. Sexual aggression?	❑	❑	❑	❑	
16. Intentionally upsetting others by rude or obnoxious behavior?	❑	❑	❑	❑	
17. Criminal behavior? Arrests?	❑	❑	❑	❑	
Functioning	**0**	**1**	**2**	**3**	
18. Intellectual or other developmental disabilities?	❑	❑	❑	❑	
19. Physical/medical problems?	❑	❑	❑	❑	
20. Family violence/tensions/conflicts (other than with youth)?	❑	❑	❑	❑	
21. Problems with school achievement?	❑	❑	❑	❑	
22. School behavior problems?	❑	❑	❑	❑	
23. Truancy/school attendance problems?	❑	❑	❑	❑	
24. Problems with sexual activity/behavior (not age appropriate)?	❑	❑	❑	❑	
Caregiver Needs and Strengths	**0**	**1**	**2**	**3**	
25. Physical/behavioral health interferes with caretaking ability?	❑	❑	❑	❑	
26. Able to supervise & discipline appropriately for child's needs?	❑	❑	❑	❑	
27. Involved in planning/providing for child's MH and other needs?	❑	❑	❑	❑	
28. Knowledge and understanding of child's strengths & needs?	❑	❑	❑	❑	
29. Able to organize & direct household, services, activities?	❑	❑	❑	❑	
30. Have nec. financial, extended fam/friends, comm. resources?	❑	❑	❑	❑	
31. Current & future residential stability?	❑	❑	❑	❑	
32. Home environment is safe for child?	❑	❑	❑	❑	
Child's Strengths (lower number indicates greater strength)	**0**	**1**	**2**	**3**	
33. Loving supportive family	❑	❑	❑	❑	
34. Interpersonal skills & social relationships	❑	❑	❑	❑	
35. Consistency in family/other significant relationships in child's life	❑	❑	❑	❑	
36. School has appropriate, effective educational plan for child	❑	❑	❑	❑	
37. Age appropriate vocational/pre-vocational skills &/or goals	❑	❑	❑	❑	
38. Capacity to enjoy positive/manage negative life experiences	❑	❑	❑	❑	
39. Optimism/positive future orientation	❑	❑	❑	❑	
40. Spiritual/religious beliefs & activities	❑	❑	❑	❑	
41. Talents or interests	❑	❑	❑	❑	
42. Involvement in community	❑	❑	❑	❑	