|  |  |
| --- | --- |
| **Last Name:** Click or tap here to enter text.**First Name:** Click or tap here to enter text.**Date of Birth:** Click or tap to enter a date.**Age:** Click or tap here to enter text.**Phone:** Click or tap here to enter text. | Date: Click or tap to enter a 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):* Click or tap to enter a date. |
| **Address:** Click or tap here to enter text. | **Reason for Request** *(pending discharge, change in situation, etc.):*Click or tap here to enter text. |
| **Email:** Click or tap here to enter text. | **Requested Services:** |
| **Type of Current Residence:**[ ]  **Community Residence** [ ]  **OCFS Placement** [ ]  **Correctional Facility** [ ]  **Own Home/Caregiver Home** [ ]  **Couch Surfing** [ ]  **Residential Treatment Facility**[ ]  **Emergency Housing** [ ]  **Substance Use Facility**[ ]  **Inpatient Setting** [ ]  **Other *(specify below)*** **Provide details:** Click or tap here to enter text. | **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** |
| **MH, SUD, DD Diagnoses:** Click or tap here to enter text. |
| *\*Contact the Child SPOA Coordinator for information about applying for these services: 607-778-1102 or* *childspoa@broomecounty.us* |
| **Insurance Type:** Click or tap here to enter text. | **Health Home Provider** *(if applicable):* Click or tap here to enter text. |
| **Dates of CPEP Visits** *(within the last year)***:**Click or tap here to enter text. | **Dates of Hospitalizations** *(within the last year)*:[ ]  **Psychiatric** Click or tap here to enter text.[ ]  **Medical** Click or tap here to enter text. |
| **Current Providers/Services:** *(include the number of visits in the last month for each provider)*Click or tap here to enter text. |
| **Describe Relationship with Service Provider(s)** *(both with individual and family as applicable):* Click or tap here to enter text. |
| ***For Child SPOA Only:*** |
| ***School District:*** Click or tap here to enter text. | ***School Placement:*** Click or tap here to enter text. | ***CSE Status:*** Click or tap here to enter text. |
| ***Describe Relationship with School:*** Click or tap here to enter text. |
| **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: Click or tap here to enter text. |

|  |  |  |
| --- | --- | --- |
| **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:**Click or tap here to enter text. |
| ***Comments:* Strengths and Challenges – *Why is this additional service needed?***Click or tap here to enter text. |
| ***Name of Person Completing Form:***Click or tap here to enter text. | ***Agency/Program:***  Click or tap here to enter text. |
| ***Signature:*** | ***Date:*** Click or tap to enter a 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* |

|  |
| --- |
|  |