Pathways, Inc.

Dear Colleague:

Enclosed please find the Pathways, Inc. referral packet used to apply for admission to the Lake Breeze Community Residence Program for Adolescents. Upon receipt of all required referral data, our multidisciplinary Referral Review Committee will consider and determine the referred youth's eligibility for admission.

Please submit the information outlined on the attached checklist to the Referral Review Committee at the following address:

Pathways, Inc.
Lake Breeze CR Referral Review Committee
3101 NYS Route 21
Canandaigua, NY 14424

If I may be of assistance in the referral process, please do not hesitate to contact me.

Sincerely,

Program Director, Lake Breeze Community Residence
(585) 394-0380

Attachments

Lake Breeze
Community Residence Program for Adolescents
Philosophy and Primary Goals

It is our mission to provide quality care, treatment and services to children and youth with serious emotional disturbance.

- We believe that each youth should be served in the least restrictive environment that is clinically appropriate.
- We are committed to ensuring a structured therapeutic environment to support the youth and his/her family as they progress through the rehabilitative process.
- Our staff is committed to the provision of guidance and training in the areas of daily living and socialization / recreational activities, behavior management training and counseling services that assist the youth in developing problem solving and coping skills.
- We are committed to the flexibility and creativity necessary to meet each individual's unique needs.
- Lake Breeze Community Residence Program is committed to the provision of a family-like setting, which reflects the individuality, and cultural diversity of the youths living in the home. Family participation is the most important factor of the child's life, care, and treatment.
- We believe in supporting each family in its effort to enhance their relationship with their child. Children are with Lake Breeze Community Residence Program for only a short period time. Children belong at home with their families, extended family members and/or primary caregivers.
- We believe that all children need to develop a sense of belonging in the community. Lake Breeze Community Residence Program strives to assist youth and their families to identify community resources that build/strengthen the youths connections within their community.

Lake Breeze Community Residence Program fully embraces the Office of Mental Health Core Values, which include:

- Developing full partnerships with families
- Being safe, nurturing, and therapeutic
- Ensuring individualized and comprehensive treatment that is creative and effective
- Striving to be culturally competent in all aspects of programming
- Using strength-based interventions, communications, and practice
- Using interventions that create the possibility for each youth to reach his/her self-defined potential
- Being short-termed and community integrated
- Using the industry's best practices and
- Employing trauma-sensitive practices

Pathways, Inc.
we put people first

PATHWAYS, INC. NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

If you have any questions about this notice, please contact the Pathways, Inc. Privacy Officer at (607) 937-3200 or in writing to 33 Denison Parkway West, Corning, New York 14830.

WHO WILL FOLLOW THIS NOTICE

This notice describes the information privacy practices followed by our employees, staff and other office personnel. This includes staff members, volunteers, and people Pathways, Inc. contracts with who we authorized to access your information to provide services to you.

YOUR HEALTH INFORMATION

This notice applies to the information and records we have about your health, health status, and the health care and services you receive at Pathways, Inc. including photographs and other images.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment We may use health information about you to provide you with treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff, contractors or other personnel who are involved in taking care of you and your health.

Different personnel at Pathways, Inc. may share information about you and disclose information to people who do not work at Pathways, Inc. in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work, ordering X-rays, and scheduling other assessments. Family members and other health care providers may be part of your medical care outside Pathways, Inc. and may require information about you that we have.

For Payment We may use and disclose health information about you so that the treatment and services you receive at Pathways, Inc. may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will cover the treatment.

For Health Care Operations We may use and disclose health information about you in order to operate Pathways, Inc. and make sure that you and our other consumers receive quality care.

For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our consumers to help us decide what additional services we should offer, how we can become more efficient, or whether certain new services are effective.

You may revoke your *Consent* at any time by giving us written notice. Your revocation will be effective when we receive it, but it will not apply to any uses and disclosures, which occurred before that time.

If you do revoke your *Consent*, we will not be permitted to use or disclose information for purposes of treatment, payment or health care operations, and we will therefore not be able to provide you with health care treatment and services.

SPECIAL SITUATIONS

We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

To Avert a Serious Threat to Health or Safety We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Required By Law We will disclose health information about you when required to do so by federal, state or local law.

Organ and Tissue Donation If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.

Workers' Compensation We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

Health Oversight Activities We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

Law Enforcement We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

Coroners, Medical Examiners and Funeral Directors We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.
Information Not Personally Identifiable We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

Family and Friends We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object.

In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care. We may also use our professional judgment and experience to make reasonable inferences that it is in your best interest to allow another person to act on your behalf to pick up, for example, filled prescriptions, medical supplies, or X-rays.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written *Authorization.* We must obtain your *Authorization* separate from any *Consent we* may have obtained from you. If you give us *Authorization* to use or disclose health information about you, you may revoke that *Authorization,* in writing, at any time. If you revoke your *Authorization,* we will no longer use or disclose information about you for the reasons covered by your written *Authorization,* but we cannot take back any uses or disclosures already made with your permission.

If we have HIV or substance abuse information about you, we cannot release that information without a special signed, written authorization (different than the *Authorization* and *Consent* mentioned above) from you. In order to disclose these types of records for purposes of treatment, payment or health care operations, we will have to have both your signed *Consent* and a special written *Authorization* that complies with the law governing HIV or substance abuse records.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

Right to Inspect and Copy You have the right to inspect and copy your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a written request to the Pathways, Inc. Privacy Officer in order to inspect and/or copy your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied access to your health information, you may ask that the denial be reviewed. If such a review is required by law, wewill select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

Right to Amend If you believe health information we have about you is incorrect or incomplete; you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this office.

To request an amendment, complete and submit a Medical Record Amendment/Correction Form to the Pathways, Inc. Privacy Officer. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

a) We did not create, unless the person or entity that created the information is no longer available to make the amendment.

b) Is not part of the health information that we keep.

c) You would not be permitted to inspect and copy.

d) Is accurate and complete.

Right to an Accounting of Disclosures You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment and health care operations. To obtain this list, you must submit your request in writing to the Pathways, Inc. Privacy Officer. It must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). We may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. Additionally Pathways, Inc. must agree to an individual's request to restrict disclosure of PHI to a health plan if the PHI relates to a health care item or service that has been paid in full to Pathways, Inc. by someone other than the health plan.

We are Not Required to Agree to Your Request If we do agree; we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you may complete and submit *the Request For Restriction On Use/Disclosure Of Medical* Information to the Pathways, Inc. Privacy Officer.

Right to a Copy of This Notice You have the right to a paper copy of this notice. You also have the right to access PHI in electronic form if requested by the individual. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. To obtain such a copy, contact the Pathways, Inc. Privacy Officer.

Right to Notice in the Event of a Breach

A breach is, generally, an impermissible use or disclosure under the Privacy Rule that compromises the security or privacy of the protected health information. An impermissible use or disclosure of protected health information is presumed to be a breach unless the covered entity or business associate, as applicable, demonstrates that there is a low probability that the protected health information has been compromised based on a risk assessment of at least the following factors:

1. The nature and extent of the protected health information involved, including the types of identifiers and the likelihood of re-identification;

2. The unauthorized person who used the protected health information or to whom the disclosure was made;

3. Whether the protected health information was actually acquired or viewed; and

4. The extent to which the risk to the protected health information has been mitigated.

Covered entities and business associates, where applicable, have discretion to provide the required breach notifications following an impermissible use or disclosure without performing a risk assessment to determine the probability that the protected health information has been compromised.

There are three exceptions to the definition of "breach." The first exception applies to the unintentional acquisition, access, or use of protected health information by a workforce member or person acting under the authority of a covered entity or business associate, if such acquisition, access, or use was made in good faith and within the scope of authority. The second exception applies to the inadvertent disclosure of protected health information by a person authorized to access protected health information at a covered entity or business associate to another person authorized to access protected health information at the covered entity or business associate, or organized health care arrangement in which the covered entity participates. In both cases, the information cannot be further used or disclosed in a manner not permitted by the Privacy Rule. The final exception applies if the covered entity or business associate has a good faith belief that the unauthorized person to whom the impermissible disclosure was made, would not have been able to retain the information.

Individual Notice Pathways, Inc. must notify affected individuals following the discovery of a breach of unsecured protected health information. Covered entities must provide this individual notice in written form by first-class mail, or alternatively, by e-mail if the affected individual has agreed to receive such notices electronically. If the covered entity has insufficient or out-of-date contact information for 10 or more individuals, the covered entity must provide substitute individual notice by either posting the notice on the home page of its web site or by providing the notice in major print of broadcast media where the affected individuals likely reside. If the covered entity has insufficient or out-of-date contact information for fewer than 10 individuals, the covered entity may provide substitute notice by an alternative form of written, telephone, or other means.

These individual notifications must be provided without unreasonable delay and in no case later than 60 days following the discovery of a breach and must include, to the extent possible, a description of the breach, a description of the types of information that were involved in the breach, the steps affected individuals should take to protect themselves from potential harm, a brief description of what the covered entity is doing to investigate the breach, mitigate the harm, and prevent further breaches, as well as contact information of the covered entity. Additionally, for substitute notice provided via web posting or major print or broadcast media, the notification must include a toll-free number for individuals to contact the covered entity to determine if their protected health information was involved in the breach.

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice at all program sites with its effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services or the Office for Civil Rights. To file a complaint with our office, contact the Pathways, Inc. Privacy Officer at 607-937- 3200 or in writing to 33 Denison Parkway West, Corning New York 14830. You will not be penalized for filing a complaint.

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Pathways, Inc. Consent for Purposes of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protected health information by Pathways, Inc. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to provide health care services.

I understand that diagnosis or treatment of me by Pathways, Inc. may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of Pathways, Inc.
Pathways, Inc. is not required to agree to a restriction that I request. However, if Pathways, Inc. agrees to a restriction that I request the restriction is binding.

I have the right to revoke this consent, in writing, at any time.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review the Pathways, Inc. Notice of Privacy Practices prior to signing this document.

The Pathways, Inc. Notice of Privacy Practices has been provided to me.

The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care services by Pathways, Inc.

The Notice of Privacy Practices for Pathways, Inc. is also provided at all program sites and on the Pathways, Inc. web site at Pathwaysinconline.org.

This Notice of Privacy Practices also describes my rights and the duties of Pathways, Inc. with respect to my protected health information.

Pathways, Inc. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

I may obtain a revised notice of privacy practices by accessing the Pathways, Inc. web site, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____
Signature of Consumer or Consumer's Representative Date

_____
Name of Consumer or Consumer's Representative

_____
Description of Consumer's Representative's Authority

AUTHORIZATION FOR RELEASE OF INFORMATION	**Name:** **Sex: M / F** **Date Of Birth:** **Pathways, Inc.** **Lake Breeze Community Residence Program**

This authorization must be completed by the patient or his/her personal representative to use/disclose protected health information, in accordance with State and federal laws and regulations. A separate authorization is required to use or disclose confidential HIV related information.

PART 1: Authorization to Release Information

Description of Information to be Used/Disclosed:

Purpose or Need for Information:

1. This information is being requested:
   - □ by the individual or his/her personal representative; or
   - x Other (please describe) Pathways, Inc. Lake Breeze Community Residence Program for Adolescents
2. The purpose of the disclosure is (please describe):

To facilitate on-going provision of services for identified youth.

From: Name, Address, & Title of Person / Organization/Facility/Program Disclosing Information	To: Name, Address, & Title of Person/Organization/ Facility / Program to Which this Disclosure is to be Made NOTE: If the same information is to be disclosed to multiple parties for the same purpose, for the same period of time, this authorization will apply to all parties listed here.
_____ _____ _____ _____ _____ _____ _____	Pathways, Inc. Lake Breeze Community Residence Program 3101 New York State Route 21 Canandaigua, New York 14424

A. I hereby permit the use or disclosure of the above information to the Person/Organization/Facility/ Program(s) identified above. I understand that:

1. Only this information may be used and/or disclosed as a result of this authorization.
2. This information is confidential and can not legally be disclosed without my permission.
3. If this information is disclosed to someone who is not required to comply with federal privacy protection regulations, then it may be redisclosed and would no longer be protected.
4. I have the right to revoke (take back) this authorization at any time. My revocation must be in writing on the form provided to me by (insert name of facility/program) ***Pathways, Inc. Lake Breeze Community Residence Program for Adolescents***
   I am aware that my revocation will not be effective if the persons I have authorized to use and/or disclose my protected health information have already taken action because of my earlier authorization.
5. I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from the New York State Office of Mental Health, nor will it affect my eligibility for benefits.
6. I have a right to inspect and copy my own protected health information to be used and/or disclosed (in accordance with the requirements of the federal privacy protection regulations found under 45 CFR S164.524).

B-1. One – Time Use/Disclosure: I hereby permit the one-time use or disclosure of the information described above to the person/ organization/facility/program identified above.

My authorization will expire:
- □ When acted upon;
- □ 90 Days fro this Date;
- □ Other _____

Continue on Next Page

Form OMH 1.1 (4-03)
State of New York

AUTHORIZATION FOR RELEASE OF INFORMATION — OFFICE OF MENTAL HEALTH

Facility/Agency Name	Patient's Name (Last, First, M.I.)	"C"/Id. No.
Pathways, Inc. Lake Breeze Community Residence		

B-2. Periodic Use/Disclosure: I hereby authorize the periodic use/disclosure of the information described above to the person/ organization/facility/program identified above as often as necessary to fulfill the purpose identified above.

My authorization will expire:
□ When I am no longer receiving services from (insert name of facility/program) ***Pathways, Inc. Lake Breeze CR Program***
□ One Year from this date:
□ Other _____

C. Patient Signature: I certify that I authorize the use of my health information as set forth in this document.

_____ _____
Signature of Patient or Personal Representative — Date

_____
Patient's Name (Printed)

_____
Personal Representative's Name (Printed)

_____
Description of Personal Representative's Authority to Act for the Patient (*required if Personal Representative signs Authorization*)

D. Witness Statement/Signature: I have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the patient and/or the patient's personal representative.

WITNESSED BY: _____
Staff person's name and title

Authorization Provided To: _____

Date: _____

To be Completed by Facility:

_____
Signature of Staff Person Using/Disclosing Information

_____
Title

_____
Date Released

PART 2: Revocation of Authorization to Release Information

I hereby revoke my authorization to use/disclose information indicated in Part 1, to the Person/Organization/Facility/ Program whose name and address is:

_____
_____
_____

I hereby refuse to authorize the use/disclosure indicated in Part 1, to the Person/Organization/Facility/Program whose name and address is:

_____
_____
_____

_____ _____
Signature of Patient or Personal Representative — Date

_____
Patient's Name (Printed)

_____
Personal Representative's Name (Printed)

_____
Description of Personal Representative's Authority to Act for the Patient (*required if Personal Representative signs Authorization*)

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Lake Breeze Community Residence

3101 State Route 21, Canandaigua, NY 14424
Residential Program License Number: 7113012

Physician's Authorization
For Community Rehabilitation Services

Authorization Type: Initial ☐ Renewal ☐

Consumer's Name: _____

Consumer's Medicaid Number: _____

I, the undersigned licensed physician, based on my review of the clinical referral information and a **face-to-face** assessment on _____ (date) for _____ (duration) minutes have determined that this consumer meets criteria for SED (Serious Emotional Disturbance) and is in need of community rehabilitation services as known to me and defined pursuant to part 593 of Title 14 NYCRR.

I have diagnosed this consumer with the following designated mental illness diagnosis according to the most current Diagnostic and Statistical Manual of Mental Disorders (DSM):

ICD-10 Diagnostic Codes	Disorder, Condition or Problem
_____ . _____	_____
_____ . _____	_____
_____ . _____	_____
_____ . _____	_____

_____
Expiration Date
(maximum duration 6 months)

_____
Physician Signature

_____
Printed Name of Physician

_____
Physician License Number or 8-digit Medicaid Number

_____
Physician National Provider ID Number

New York State Western Region Application for Community Residence (CR) Programs

Special Note: Thank you for your referral to the community-based programs of the New York State Western Region. All programs listed below are co-ed and licensed by the Office of Mental Health, whose regulations state that **a letter of support from the youth's county-of-origin Single Point of Access (SPOA) committee is required to accompany the referral to the program(s)**. Contact the youth's county-of-origin SPOA coordinator for instructions regarding the SPOA process, as some counties vary in their process.

Instructions: Place an X in the space provided next to the CR program(s) that you would like your child to be considered for. For referrals to multiple programs, rank your preference by putting a number "1" next to your first choice, "2" next to your second choice, and so on.
*Please note the age requirements of each individual program.

Community Residence Programs:

Child & Family Services _____Lee Randall Jones CR (ages 5-14) 51 Rossler Avenue Cheektowaga, NY 14206 Phone (716) 894-1981 Fax (716) 894- 0999 residentialreferrals@cfsbny.org	Villa of Hope _____Tuckahoe Road CR (ages 12-18) 6313 Tuckahoe Road Williamson, NY 14589 Phone (315) 589-2547 Fax (315) 589-8190 www.villaofhope.org	Community Missions _____Aurora House CR (ages 12-18) 5311 Ernest Road Lockport, NY 14094 Phone (716) 433-1905 Fax (716) 433-2081 www.communitymissions.org
Pathways, Inc. _____Conable House (ages 5-12) 5 Vargason Place Bath, NY 14810 Phone (607) 664-1128 Fax (607) 664-1196 www.pathwaysforyou.org	Pathways, Inc. _____Lake Breeze CR (ages 13-17) 3101 State Route 21 South Canandaigua, NY 14424 Phone (585) 394-0380 Fax (585) 394-0385 www.pathwaysforyou.org	Rochester Psychiatric Center _____Smith Road CR (ages 12-18) 446 Smith Road Webster, NY 14580 Phone (585) 241-1778 Fax (585) 787-1683
_____Glove House CR (ages 12-18) 380 Laurentian Place Elmira, NY 14904 Phone (607) 733-1335 Fax (607) 733-2862	_____Cattaraugus Rehabilitation Center (ages 12-18) 2399 N. Union Street Ext. Olean, NY 14760 Phone (716) 375-4601 Fax (716) 375-5190 centralintake@rehabcenter.org	

ADMISSION CRITERIA

Minimum Regulatory Requirements for Admission: According to the New York State Office of Mental Health regulations (Part 594.8), youth admitted to a Community Residence program must meet the following *minimum criteria*:

1. Age: Each program serves a specific age range. Refer to Page 1 (cover sheet) of this referral packet to determine which programs serve which age ranges.
2. Designated mental illness diagnosis.
3. Substantial problems in social functioning due to a serious emotional disturbance (SED) within the past year.
4. Serious problems in family relationships, peer/social interaction, or school performance.
5. Serious and persistent symptoms of cognitive, affective, and personality disorders.
6. A level of service need which requires multi-agency intervention and involvement.
7. Capability of self-preservation, as evidenced by successfully completing a Standard Capability of Self-Preservation Test at the specific program(s) facility.
8. Residency: applications are accepted from the 19 counties within the NYS OMH Western New York Regional Office catchment areas for children and youth.

Additional Considerations for Eligibility for Admission at the Discretion of Each Program: Each program may request additional information for youth with the following criteria, and the resulting determination regarding eligibility for admission is made at the discretion of each program:

- ✓ IQ: measured IQ of at least 70. An IQ below 70 requires additional referral information for consideration.
- ✓ Medication: acceptance of medication therapy, if prescribed
- ✓ Other Medical Needs: special medical needs which cannot be safely or adequately met by the program
- ✓ School: willing and able to participate in school or another type of day program.
- ✓ Physical Aggression: history of physical aggression toward others
- ✓ Suicidal Gestures: history of self-harm and/or suicidal gesture or attempt
- ✓ Homicidal Gestures: history of homicidal ideation, gestures, or attempt
- ✓ Fire Setting: history of fire-play or fire-setting
- ✓ Sexualized Behavior: history of sexualized behavior
- ✓ Adjudication: as a Juvenile Delinquent (JD) or as a Person In Need of Supervision (PINS)
- ✓ Other: as identified based on each individual referral

Note: Each program is empowered to make decisions regarding each youth's acceptance into the program in accordance with New York State Office of Mental Health regulations (Part 594.8). However, no individual will be discriminated against or excluded from the program on the basis of race, religion, gender, sexual orientation, or ethnic origin.

FINANCIAL INFORMATION

Community Residence (CR) Programs

General Information:

- Funding for the residential fees and services for a child in the Community Residence programs is paid by Supplemental Security Income (SSI) and Medicaid reimbursement.
- *Parent/guardian consent is required for these benefits to be paid directly to the placement agency as the "representative payee"during the youth's placement in the program.*
- If a youth does not have SSI, you are required to initiate the application process by obtaining, completing, and submitting the application to the Social Security Administration. You can obtain an SSI application by visiting the Social Security Website http://www.ssa.gov/online/ssa-3820.pdf or by calling the toll free number 1-800-772-1213 (TTY 1-800-325-0778).
- If a youth does not have Medicaid, you are required to initiate the application process by obtaining, completing, and submitting the application to your local county Medicaid office.

Important Exceptions & Examples of when a youth may not be eligible for SSI, or may receive a reduced or partial payment due to other funding he/she receives, include, but are not limited to:

- Adoption Subsidy: When an Adoption Subsidy is received by the youth's parent/guardian, this amount is subtracted from the amount SSI will pay for the youth's care in a CR.
- Child Support Payments: When Child Support Payments are received by the youth's parent/guardian, this amount is subtracted from the amount SSI will pay for the youth's care in a CR.
- Survivor Benefits or SSD: When Survivor Benefits or SSD are received for the youth, this amount is subtracted from the amount SSI will pay for the youth's care in a CR.
- Youth in the Guardianship of their County Department of Social Services: If a youth's guardianship is with their county Department of Social Services (DSS) receipt of federal Title 4E benefits should be discussed with the placement agency.

For all of the examples above, arrangements must be made by the parent/guardian with the placement agency for the parent/guardian to pay the agency for the difference not paid by SSI.

Private Payment Option: Arrangements can be arranged by the parent/guardian with the placement agency.

QUESTIONS? If you have questions, concerns, or circumstances that are not addressed above:

(1) Contact the placement agency directly.
(2) Contact your local Social Security Administration and/or Medicaid offices.

The youth's parent/guardian is ultimately responsible for payment.

HOW TO APPLY TO A COMMUNITY RESIDENCE (CR):

1. Complete the enclosed Referral Application and assemble a complete referral application packet, including the following:

Minimum Regulatory Requirements for Referral: According to the New York State Office of Mental Health regulations (Part 594.8), a referral for admission to a Community Residence program must include:

. _____ Completed Referral Application

. _____ Documentation of support of the referral from the youth's county-of-origin Single Point of Access (SPOA) committee

. _____ Updated medical report (within the past 90 days)

. _____ Psychosocial assessment (within the past 90 days)

. _____ Psychiatric evaluation (within the past 90 days)

. _____ Educational assessment (within the past year)

. _____ Signed parent/guardian consent for referral/admission consideration

. _____ Description of the child's current behaviors and significant strengths and problems

. _____ Documentation that potentially less restrictive community, home and/or extended nonresidential services have been reasonably explored and are either not available or have not been successful.

. _____ Physicians Authorization for Community-Based Residential Services (note: select agencies may also request a copy of the physician's progress note that verifies a face-to-face contact on the date of the physician's authorization)

Additional Requested Information:

. _____ Copy of Birth Certificate (if youth is in custody/guardianship of adult(s) other than listed, include official documentation of custody status)

. _____ Copy of Immunizations

. _____ Individualized Education Plan (IEP) if applicable (for current school year)

. _____ Treatment plan (most recent – from current provider as applicable)

. _____ Individualized crisis management plan (most recent – from current provider as applicable)

. _____ Psychological Evaluation (most recent - within the past 3 years)

. _____ Any information relevant to the Admission Criteria "Additional Considerations" described on the previous page of this packet.

2. Submit application to the youth's county-of-origin SPOA committee. Contact SPOA coordinator for further directions in this step, as the process varies by county. *REMINDER:* NYS OMH regulations require documentation of SPOA's support of the referral to CR.

3. **The CR program staff will call you to arrange an interview with the referred youth and to invite you, the youth, and their family to tour the program and learn more information about the program (if this has not already taken place prior to referral).**
4. **Each program has a committee that reviews the referred youth and family's ability to benefit from and take part in the program. You will be invited to come to this meeting, and you will be informed in writing of the committee's decision.**
5. **If appropriate, the youth will be scheduled for a pre-placement visit(s).**
6. **If appropriate, anticipated opening(s) and an admission date will be discussed with the family.**

REFERRAL APPLICATION
FOR COMMUNITY RESIDENCE (CR)

YOUTH INFORMATION:

Youth's Name:_____
(Last) (First) (Middle)

Date of Birth:_____ Gender:_____ Ethnicity:_____

Youth Citizenship: ◯ U.S. citizen ◯ Other (specify:_____)

Youth is Currently: ◯ Home ◯ Hospital ◯ Residential Placement (specify:_____)

Current Address:_____

_____ County of Origin:_____

Telephone Number: (_____) _____-_____ extension: _____

Legal Guardian:_____ Relationship to Youth:_____

Name of Party Holding Custody (ex: DSS, OCFS):_____

Custodian's Address:_____

Home Phone: (_____) _____-_____ Business Phone: (_____) _____-_____

REFERRAL SOURCE INFORMATION:

Name of Referral Agent:_____

Title/Relationship to Youth:_____

Referral Agency:_____

Address:_____
(Street) (City) (State) (Zip) (County)

Telephone Number: (_____) _____-_____ extension: _____

Reason for Referral:_____

_____

What is the anticipated permanency/discharge plan for this youth?_____

_____

FAMILY INFORMATION:

Mother's Name: Date of Birth:

Race/Ethnicity (optional): Religious/Spiritual Affiliation (optional):

Address: Telephone: ( ) -

County of Origin:

Place of employment: Telephone: ( ) -

Work Address:

Marital Status: If applicable, date and to whom:

Name of Spouse/Significant Other: Date of Birth:

Father's Name: Date of Birth:

Race/Ethnicity (optional): Religious/Spiritual Affiliation (optional):

Address: Telephone: ( ) -

County of Origin:

Place of employment: Telephone: ( ) -

Work Address:

Marital Status: If applicable, date and to whom:

Name of Spouse/Significant Other: Date of Birth:

Siblings:

NAME	**AGE**	**ADDRESS**	full	half	step	other

Additional Significant Caring Adults in Referred Youth's Life:

NAME	RELATIONSHIP	PHONE
		( ) -
		( ) -
		( ) -
		( ) -
		( ) -

YOUTH'S PLACEMENT HISTORY:

Age/Onset of Psychiatric Problems (describe):_____

Age of First Psychiatric Treatment (describe):_____

Psychiatric Hospitalizations:

Facility	*Dates*	*Therapist/Psychiatrist*	*Reason for hospitalization*

Other placements (list previous placements including OMH and DSS/OCFS placements):

Facility/Program	*Dates*	*Therapist/Psychiatrist*	*Reason for placement*

YOUTH'S MENTAL HEALTH INFORMATION:

Most recent psychiatric diagnosis (DSM 5):

Primary Diagnosis: _____

Other Diagnoses: _____

_____

_____

_____

_____

Diagnosed by (name & title):_____ Date of Diagnosis:_____

Current therapist:_____ Telephone: (_____) _____-_____

Agency/Facility Name:_____

Agency Address:_____
(Street) (City) (State) (Zip) (County)

Current psychiatrist:_____ License #:_____

Agency/Facility Name:_____ Telephone: (_____) _____-_____

Agency Address:_____
(Street) (City) (State) (Zip) (County)

Prescribed Psychotropic Medications:

Medication	Dosage	Schedule	PRN? Y/N

Does the referred youth have a history of:

	YES	Date & Description of Most Recent Incident	NO	UNKNOWN
Fire setting				
Sexual Perpetration				
Sexual Victimization				
Sexualized Behaviors				
Verbal Aggression				
Physical Aggression				
Suicidal: Ideation				
Gestures				
Attempts				
Other Self-Harm				
Homicidal: Threats				
Gestures				
Substance Abuse				
Criminal Activities				
Legal Adjudication(s)				

Additional Information:_____

Drug/Alcohol History:

Please list any substance abuse assessments or treatments received by the referred youth:

Facility/Program	*Dates*	*Discharge Recommendations*

Is ongoing/further treatment indicated at this time?_____Yes _____No

If yes, describe:_____

YOUTH'S MEDICAL INFORMATION:

Physician:_____ Telephone: (_____) _____-_____

Address:_____
(Street) (City) (State) (Zip) (County)

Date of last physical exam:_____ Date of Last COVID Test:_____

Does this youth have allergies? If yes, specify:_____

Describe any ongoing medical needs/concerns (i.e., asthma, seizures, acne):_____

_____

Dentist:_____Telephone: (_____) _____-_____

Address:_____
(Street) (City) (State) (Zip) (County)

Date of last dental exam:_____

Other Medical Providers currently providing services to this youth:

Name of Provider	***Address & Phone***	***Reason for Services***

Prescribed NON-Psychotropic Medications:

Medication	Dosage	Schedule	PRN? Y/N

YOUTH'S EDUCATIONAL INFORMATION:

Current School:_____ Grade:_____

Address:_____
(Street) (City) (State) (Zip) (County)

School Counselor:_____ Telephone: (_____) _____-_____

Current Educational Placement: ◯ Regular ◯ CSE ◯ 504 Plan

CSE Classification (check all that apply):

◯ NONE ◯ Emotionally Disturbed ◯ Learning Disabled

◯ Intellectually Disabled ◯ Speech Impaired ◯ Visually Impaired

◯ Hearing Impaired ◯ Other Health Impaired ◯ Other:_____

Diploma Eligibility (grades 9-12 only): ◯ Regents ◯ Local ◯ IEP Year:_____

Home School District:_____ Telephone: (_____) _____

Address:_____
(Street) (City) (State) (Zip) (County)

IQ Test Results (if available):

Date Tested:_____ Test Administered:_____

Test Results: Performance:_____ Verbal:_____ Full Scale:_____

Test Administered by:_____ Title:_____

Estimated Functioning Level: ◯ Above Average ◯ Average

◯ Borderline ◯ Intellectually Disabled

FINANCIAL INFORMATION:

Youth's Medicaid Number:_____ County:_____

Other Medical Insurance Provider:_____

Policy Holder's Name:_____ Policy Number:_____

Does youth currently receive an SSI benefit? ◯ Yes ◯ No

If no, date SSI application was filed:_____

Does youth currently receive a Social Security Survivor's Benefit? ◯ Yes ◯ No

Is child support currently paid for this youth? ◯ Yes ◯ No

If yes, who receives the child support payment?_____

Is an adoption subsidy currently paid for this youth? ◯ Yes ◯ No

If yes, who receives the adoption subsidy?_____

Special Note: Any income received by the youth or on behalf of the youth may reduce the amount SSI pays to the placement agency. In these cases, the income received is expected to go towards the cost of care for the youth while placed with the agency.

The youth's parent/guardian is ultimately responsible for payment.

Referral Application Completed By:_____ Date:_____

CONSENT & SIGNATURES (required):

I have reviewed this referral application, and I consent to being considered for admission to the program(s) indicated.

Youth Signature:_____ Date:_____

I have reviewed this referral application, and I consent to my child being considered for admission to the program(s) indicated.

Parent/Guardian Signature:_____ Date:_____

CKC 6/20/2011; revised 8/4/2011

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HEALTH INTAKE FORM

Youth:_____ Completed by: _____

Date of Birth:_____,_ Date Completed: _____

A. YOUTH DESCRIPTION
Sex:_____ Race:_____ Height: _____ ft _____ inches

Weight:_____ Eye Color:_____ Hair Color: _____

Physical characteristics (scars, identifying marks, pierced ears, etc.):_____
_____

B. PROVIDERS/RECORDS
1. Primary Care Provider: _____
(name) (address)

2. Specialty Care Provider:_____
(name) (address)

3. Dentist:_____
(name) (address)

4. Last physical:_____
(Date) (where/by whom)

5. Health records:
Present?_____Yes If present, where?_____
_____No if not present, sent for?_____Yes - by whom?_____
Date requested:_____

C. YOUTH'S MEDICAID #:_____
Is there a health insurance plan that covers this youth?_____Yes _____No
If yes, is this coverage for this youth expected to continue?_____yes_____No
If yes, policy name and contract #_____

D. SIGNIFICANT FAMILY HEALTH HISTORY
Mother_____
_____

Father_____
_____

Siblings_____
_____

Extended Family_____
_____

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HEALTH HISTORY

Problem/Issue		If yes, provide explanation or comment
Problem pregnancy	___yes ___no	_____
Problem delivery	___yes ___no	birth weight: _____
Problem walking	___yes ___no	age: _____
Problem talking	___yes ___no	age: _____
Problem toilet training	___yes ___no	age: _____
Major illness	___yes ___no	_____
Operations	___yes ___no	_____
Head injuries	___yes ___no	_____
Seizures (History)	___yes ___no	_____
Other hospitalizations	___yes ___no	_____
Prone to strep throat	___yes ___no	_____
Prone to ear aches	___yes ___no	_____

E. DISEASES (state diseases child has had and age when they developed)

Infections (chicken pox, diphtheria, measles, mumps, whooping cough, typhoid, meningitis, encephalitis, syphilis, gonorrhea, poliomyelitis, scarlet fever, etc.)

Other (convulsions, diabetes, rheumatic fever, chorea, rickets, kidney disturbances, etc.)

F. IMMUNIZATIONS

	DATES RECEIVED				
	#1	#2	#3	Booster	Booster
Diphtheria-Pertussis-Tetanus					
Oral Polio Vaccine Trivalent					
COVID-19 Vaccine					

	DATES RECEIVED	
Tetanus-Diphtheria (Td)		
Mumps, Measles, Rubella		

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G. CURRENT HEALTH ISSUES

Food allergies	___yes ___no	what? _____ Reactions: _____
Pet allergies	___yes ___no	what? _____ Reactions: _____
Bee sting reactions (life threatening)	___yes ___no	what? _____ Reactions: _____
Medication allergies	___yes ___no	what? _____ Reactions: _____
Other allergies	___yes ___no	what? _____ Reactions: _____
Diabetes	___yes ___no	_____
Hepatitis B carrier	___yes ___no	_____
Seizures (current)	___yes ___no	_____
Enuresis (bedwetting)	___yes ___no	_____
Encopresis (soiling)	___yes ___no	_____
Dental problems	___yes ___no	_____
Wears glasses	___yes ___no	_____
Sexually active	___yes ___no	_____
Ever used contraception	___yes ___no	what _____
Ever had any Venereal disease	___yes ___no	_____
Alcohol use	___yes ___no	_____
Tobacco use	___yes ___no	_____
Menstruation	___yes ___no	started when? _____ Last period when? _____
Pregnant now	___yes ___no	_____

H. MEDICATION

1. Is the youth on any medication right now? ___yes_____no
   If yes: Drug use and dosage _____
   Has the youth been taking this regularly? _____

Prescribing doctor_____
Do you have a follow-up appointment?_____ When? _____
If not, when is the youth due to return?_____

2. If more than one medication, give same information below for each medication.

_____
_____
_____
_____

3. Besides above, has the youth been on other psychotropic medication in the past?
___yes
___no

If yes, what medication and what response?_____
_____

I. NOTES: Use this section if more space is needed, or to cover any other health issue not covered elsewhere.

_____
_____
_____
_____
_____
_____
_____
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