NASSAU COUNTY
SINGLE POINT OF ACCESS (SPOA)
CHILDREN'S INTENSIVE MENTAL HEALTH PROGRAMS

Date of Referral: _____

Child's Name: _____ Date of Birth: _____ Gender: _____

Social Security Number: _____ Age: _____

Address: _____

Town: _____ Zip: _____ Phone: _____

Legal Guardian: _____ Relationship: _____

Address/Telephone: (if different): _____

Emergency Contact: _____ Phone #: _____

Insurance Co./Managed Care Provider: _____

Insurance # / Medicaid CIN#: _____

Does the child have? SSI ☐ SSD ☐ Child Health Plus ☐

Does child receive personal income? (i.e. *trust fund, survivor's benefits, etc.*) _____ ☐ Yes ☐ No ☐ Unknown

If **yes**, how much money does he/she receive on a monthly basis? _____ ☐ Over $700 ☐ Under $700

Referral Source:

Name: _____ Phone: _____

Agency: _____ Fax: _____

Program: _____

Address: _____

Reason for Referral and Current Service Needs Briefly indicate why this youngster needs intensive In-Home or Out-of-Home services:

_____

_____

_____

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Last revised: 2/1/2009

Child's Name:_____

Please check service category for which child is being referred.

IN-HOME SERVICES

- ☐ Supportive Case Management (SCM)
- ☐ Intensive Case Management (ICM)
- ☐ Coordinated Children's Services Initiative (CCSI)
- ☐ Home & Community Based Services Waiver (HCBS)
- ☐ Clinical Care Coordination Team (CCCT)

PLACEMENT OUT OF HOME

- ☐ Family Based Treatment - Turnabout
- ☐ Teaching Family Homes
- ☐ Community Residence
- ☐ Residential Treatment Facility (RTF)

I agree to this application for Intensive Child and Adolescent Mental Health Services.

Parent/Guardian Signature: _____Date: _____

Parent/Guardian Name (Print): _____

Child's Signature (If 14 years or older): _____

Witness Signature: _____Date: _____

Witness Name (Print):_____

Child and Family Information

Child's Present Living Arrangement

☐ Parent(s) ☐ Group Home ☐ Hospital ☐ Other Relatives ☐ Foster Home

☐ Residential ☐ Family Based Treatment ☐ Shelter ☐ Other:_____

Primary Language

Child:_____ Family:_____

Race/Ethnicity

☐ White ☐ Asian/Pacific Islander ☐ Hispanic ☐ Caribbean

☐ African American ☐ Native American/Alaskan ☐ Other:_____

Significant Cultural/Religious Considerations:_____

_____

Custody Status

☐ Biological Parents

☐ Adoptive Parents

☐ Other Family or Legal Guardian, please specify_____

☐ Other, please specify_____

☐ DSS- if yes-

Case worker:_____ Phone:_____

Drug/Alcohol Involvement

Please specify past and/or current use of drugs and alcohol: (Please provide treatment history)

_____

_____

_____

_____

_____

_____

_____

_____

Child's Treatment and Services History

	Enter number *For none please enter 0*
Number of Psychiatric hospitalizations in last 12 months	_____
Number of Psychiatric hospitalizations in last 6 months	_____
Number of Emergency Room/Evaluation visits in last 6 months	_____
Number of Arrests in last 6 months	_____
Number of Incarceration in last 6 months	_____

Hospital / Agency Name	**Date From**	**Date To**

Child's Name:_____

Has child been a victim of physical abuse? ☐ Yes ☐ No Most recent occurrence? (mo/yr)_____

Has child been a victim of sexual abuse? ☐ Yes ☐ No Most recent occurrence? (mo/yr)_____

CPS involvement? ☐ Past ☐ Present _____
(Name of Case Worker)

History of Past and Present Services: (Check all that apply)

☐ HCBS (Waiver)	☐ Past	☐ Present
☐ Intensive Case Management	☐ Past	☐ Present
☐ Specialized education services	☐ Past	☐ Present
☐ Family Based Treatment	☐ Past	☐ Present
☐ Foster Care	☐ Past	☐ Present
☐ Residential Treatment Facility	☐ Past	☐ Present
☐ Probation	☐ Past	☐ Present
☐ Community Residence	☐ Past	☐ Present
☐ OMRDD Waiver Services	☐ Past	☐ Present
☐ Home Based Crisis Intervention (Pathways and Aftercare)	☐ Past	☐ Present
☐ DSS/OCFS Placement	☐ Past	☐ Present
☐ Day Treatment	☐ Past	☐ Present
☐ Clinic Treatment	☐ Past	☐ Present
☐ DSS Preventive Services	☐ Past	☐ Present
☐ Respite – Planned	☐ Past	☐ Present
☐ DSS Protective Services	☐ Past	☐ Present
☐ Family Support Services	☐ Past	☐ Present
☐ Private/individual therapy	☐ Past	☐ Present
☐ Medication management	☐ Past	☐ Present
☐ General hospital psychiatric inpatient	☐ Past	☐ Present
☐ State psychiatric facility	☐ Past	☐ Present
☐ Person in need of supervision (PINS)	☐ Past	☐ Present
☐ Person in need of supervision diversion	☐ Past	☐ Present
☐ Treatment of Trauma (**specify below**)	☐ Past	☐ Present
☐ Other (**specify below**)	☐ Past	☐ Present

Child's Name:_____

DSM-IV Diagnosis

Diagnostic Code Description:

Axis I _____ _____

_____ _____

_____ _____

Axis II _____ _____

_____ _____

Axis III _____ _____

Axis IV _____ _____

Axis V _____ _____

Areas of Strength

Child: _____

_____

_____

_____

_____

_____

_____

Family: _____

_____

_____

_____

_____

_____

Education

Home School District:_____

Name of School: _____ Grade Level: _____

☐ Regular Education ☐ Special Education Class Type:_____
☐ Home Instruction

CSE Classification: _____ Date of Classification: _____

IQ Score: _____ _____ _____ _____
Verbal Performance Full Scale Test Date

Areas of Need:

Scale

0 Not Evident Child does not display this symptom/behavior

1 Mild This symptom/behavior exists, but there is no impairment (loss of effectiveness) in carrying out daily activities or in meeting major role requirements.

2 Moderate This symptom/behavior exists. This child maintains an appropriate level of functioning in daily activities and major roles only with difficulty and increased effort and support.

3 Severe This symptom/behavior exists. Definite impairment exists in daily activities. The child is unable to perform one or more major roles at any level. The child may not be allowed to remain in one or more major roles due to severity of symptom/behavior.

If you do not know the information, please consult with the child's clinician.

Scale: 0 Not Evident 1 Mild 2 Moderate 3 Severe

Current Rating: All activity that has occurred ***within the last 3 months*** **History:** A History is any activity that has occurred *more* ***than 3 months*** ago**.**	**Current Rating**	**History Yes**	**Unknown**
Suicidal ideation		☐	☐
Psychotic symptoms (i.e. hallucinations)		☐	☐
Depression		☐	☐
Anxiety		☐	☐
Dangerous to self		☐	☐
Dangerous to others		☐	☐
Temper tantrums		☐	☐
Sleep disorders		☐	☐
Enuresis/encopresis		☐	☐
Sexually inappropriate (i.e. inability to maintain boundaries)		☐	☐
Sexually acting out (i.e. promiscuous behavior)		☐	☐
Sexually aggressive (i.e. perpetrator or at risk for potential perpetration)		☐	☐
Verbally aggressive		☐	☐
Physically aggressive		☐	☐
Fire setting Specify incidents:		☐	☐
Animal cruelty Specify incidents:		☐	☐
Eating disorder		☐	☐
Self-injury		☐	☐
Runaway		☐	☐

Child's Name:_________________________

Probation (if applicable)

Check all that apply

☐ Person in Need of Supervision (PINS) ☐ School ☐ Family

☐ Person in Need of Supervision Diversion

☐ Juvenile Delinquent (JD)

Probation contact:____ Phone # ___________________________

☐ Family Offense (FO)

Family Court Judge: ____

Court Attorney: ____ Phone # ___________________________

Law Guardian:____ Phone # ___________________________

Program: ____

Probation Officer/Contact Person: __________________________________ Docket # ___________________________

Supervising Probation Officer: ____

Please attach a copy of the conditions of probation and a copy of the disposition.

= =

Send completed application, including parental signature on Page 2 and a signed Release of Information to:

SPOA Unit/Children's Services
Nassau County Department of Mental Health, Chemical
Dependency and Developmental Disabilities Services
60 Charles Lindbergh Boulevard, Suite 200
Uniondale, New York 11553-3687

Phone: (516) 227-7057
Fax: (516) 227-7076

Please note that incomplete applications may be delayed or returned.

(1) Psychosocial Assessment

This assessment should be completed within the past **year** and document the following information about the child. **If the application is for a Community Residence (CR) or for Family Based Treatment (FBT), then the psychosocial must be current within 90 days, completed by a Masters Level Human Services professional.**

- developmental history and milestones
- current living environment
- family dynamics
- education
- emotional factors
- legal involvement

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(2) Psychiatric Assessment

The psychiatric assessment must be current within **12 months** and completed by a **M. D. If the request is for Community Residence (CR) or Family Based Treatment (FBT), it must be 90 days or newer.**

The psychiatric assessment must include:

- the child's current mental health status
- a DSM-IV diagnosis (Axis I-V)
- a history of prior psychiatric care, course of treatment-include dates and length of stay
- past and present psychotropic medications (if any) and the child's response
- discharge summary i.e. outpatient COPS appointment clinic, date, time, and additional community based mental health services

(3) Physical/Medical Assessment

This assessment must be current within the past **year** and completed by a **M. D.** Physicals from Nurse Practitioners are not accepted. . **If the application is for a Community Residence (CR) or for Family Based Treatment (FBT), then the physical must be current within 90 days.**

Please include any known medical problems (i.e. allergies, asthma, etc)

(4) Psychological Evaluation

A psychological evaluation is required to have been completed within the last **2 years** by a psychologist if the child's IQ is between **50-69**. The Vineland Adaptive Behavior Scale can also be used to assess adaptive social functioning. If your agency does not have access to the Vineland Adaptive Behavior Scale, please contact the CSPOA office.

IQ Score _____ _____ _____ _____

Full Scale Performance Verbal Test Date

(5) Educational Assessment:
This section is not necessary for children who are applying for in-home services. If a child is deemed appropriate for out of home services, SPOA will request this additional information

Please indicate the supporting documentation provided as attachments:
***** Note: Referrals for out of home placements require all of the below

- ☐ Psychosocial/Developmental History ***(required)***
- ☐ Psychiatric Evaluation
- ☐ Educational/Vocational Summary
- ☐ Discharge or Treatment Summary
- ☐ Psychological Evaluation
- ☐ Individualized Educational Plan (IEP)
- ☐ Probation Reports
- ☐ Medical Reports

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