

## **DEPARTMENT OF MENTAL HEALTH**

Dr. Robert L. Yeager Health Center  
50 Sanatorium Road, Building F  
Pomona, New York 10970  
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**Michael Leitzes, MBA**  
*Commissioner*

## **ROCKLAND COUNTY CHILDREN'S SPOA**

Attached is the Rockland County Single Point of Access (SPOA) Referral Form for Children with Serious Emotional Disturbance.

The goal of the Single Point of Access is to insure that all requests for services are reviewed in a timely manner, in order to help children needing assistance gain access to the level of support and individualized care appropriate to their needs.

This form is to be used to refer a child for any of the Case Management Programs for Children: (Intensive, Supportive, Home and Community Based Waiver or CAFE (Children and Families Empowered). This application is also needed to support referrals to Residential Treatment Facilities, Community Residences or Family Based Treatment programs. Based upon the information received, the CANS assessment (to determine the level of service needed), the SPOA Committee will finalize the level of care based on the need and availability.

Please fill out the consents completely and answer the questions to the best of your ability. (Please don't forget phone numbers, address and insurance information). We need the following documentation in support of the service being requested.

- **Most recent complete psychiatric evaluation (completed within the last year).**
  - **A Psychosocial Evaluation/IEP**
  - **Referrals from hospitals & RTF's must include a comprehensive discharge plan.**
- ❖ **Please be advised that without the completed consents and the supporting documents (Psychiatric Evaluation), the SPOA Committee will be unable to process this application.**

The Rockland Single Point of Access Committee For Children meets on a weekly basis. Someone from committee may contact you for clarification, or for additional information.

**SPOA Application or inquiries regarding the SPOA process and/or services should be sent to:  
Dr. Susan Hoerter - Children's SPOA Coordinator @ the Rockland County Department of Mental Health,  
located @ 50 Sanatorium Rd. Bldg. F, Pomona, NY 10970. Telephone inquiries @ 845-364-2275.**



**Children's Single Point of Accountability – Rockland County  
CONSENT FOR RELEASE OF INFORMATION**

**PLEASE PRINT CLEARLY**

<b>Child's Name (Last, First, Middle Initial)</b>	<b>Sex</b>	<b>Date of Birth</b>
<b>Facility Name</b>	<b>Unit/Ward #</b>	

**Extent or Nature of Information to be Disclosed:**

- Most Recent Complete Psychiatric Evaluation
- Psychosocial Summary
- Psychological Evaluation (If Available)
- Current Medical Report with TB Status (within 1-year)
- Single Point of Accountability Application

**Purpose or Need For Information:**

**Referral to Children's Case Management, WAIVER/café or Network**

<b>From:</b> _____ <b>Name</b>	<b>To:</b> <u>Rockland County Children's SPOA Committee</u> <b>Name</b>
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<b>Address:</b> _____ _____ _____	<b>Address:</b> <b>Rockland County</b> <b>Department of Mental Health</b> <b>50 Sanatorium Rd. Bldg. F</b> <b>Pomona, NY 10970</b> <b>Attention: Dr. Susan Hoerter</b> <b>Telephone: 845-364-2275</b>
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Name of Person/Organization/Facility/Program Disclosing Information:

\_\_\_\_\_

Title of Person/Organization/Facility/Program to which Disclosure is to be made:  
**Attention: Single Point of Access and Accountability of Rockland County**

A. I hereby authorize the one-time release of the above information to the Person/Organization/Facility/Program as identified above. I understand that the information to be released is confidential and protected from disclosure. I also understand that I have the right to cancel my Permission to Release Information at any time.

**My Consent to Release Information will expire when acted upon, or within 90-days from this date, whichever occurs first.**

<b>Signature of Parent/Guardian</b>	<b>Relationship</b>	<b>Date Signed</b>
<b>Signature of Witness</b>	<b>Title</b>	<b>Date Signed</b>

B. I hereby authorize the Periodic Release of the above information to the Person/Organization/Facility/Program identified above as often as necessary to plan for/provide care and treatment. I understand that the information to be released is confidential and protected from disclosure. I also understand that I have the right to cancel my Permission to Release Information at any time.

**My Consent to Release Information to the Person/Organization/Facility/Program as identified above will expire when I am no longer receiving services from such Person/Organization/Facility/Program, or 1-year from this date, whichever occurs first.**

<b>Signature of Parent/Guardian</b>	<b>Relationship</b>	<b>Date Signed</b>	<b>Signature of Witness</b>	<b>Title</b>	<b>Date</b>
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<b>Signature of Staff Person Releasing Information</b>	<b>Title</b>	<b>Date Released</b>
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**Single Point of Access/Rockland County Child Referral Form**

<b>CHILD'S NAME:</b>	
<b>ADDRESS:</b>	
<b>PHONE:</b>	

Is this child's place of residency temporary?     Yes                       No

**Parent/Guardian:**

**Father/Guardian**

**Mother/Guardian**

<b>Name:</b>		
<b>Address:</b>		
<b>Phone:</b>		
<b>Relationship:</b>	<input type="checkbox"/> Biological Parents <input type="checkbox"/> Step-Parent <input type="checkbox"/> Adoptive Parent <input type="checkbox"/> Legal Guardianship <input type="checkbox"/> DSS/Foster Care <input type="checkbox"/> Division of Family/Youth <input type="checkbox"/> Relatives <input type="checkbox"/> Currently Resides w/ Child	<input type="checkbox"/> Biological Parents <input type="checkbox"/> Step-Parent <input type="checkbox"/> Adoptive Parent <input type="checkbox"/> Legal Guardianship <input type="checkbox"/> DSS/Foster Care <input type="checkbox"/> Division of Family/Youth <input type="checkbox"/> Relatives <input type="checkbox"/> Currently Resides w/ Child

**What Type of Health Coverage for this Child? (Check all that apply)**

<input type="checkbox"/> Blue Cross/Blue Shield or 3 <sup>rd</sup> Party Insurance <input type="checkbox"/> *Medicaid - ID# _____ <input type="checkbox"/> Child Health Plus	<input type="checkbox"/> Other (Specify) _____ <input type="checkbox"/> None <input type="checkbox"/> Don't Know
<b>Medicaid Status:</b>	<input type="checkbox"/> Eligible <input type="checkbox"/> Pending <input type="checkbox"/> Not Applied
<b>Is the Child a Citizen of the United States?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Does the Child have any Income of his/her own?</b> Example: SSI	<input type="checkbox"/> Yes _____ <input type="checkbox"/> No
<b>What is the Child's Social Security #?</b>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> - <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> - <input type="checkbox"/>

**What is the Child's Current Living Situation? (Choose One)**

<input type="checkbox"/> Independent Living <input type="checkbox"/> 2-Parent Family <input type="checkbox"/> 1-Parent Family <input type="checkbox"/> 2-Parent Adoptive Family <input type="checkbox"/> 1-Parent Adoptive Family <input type="checkbox"/> Relative's Home <input type="checkbox"/> DSS Family Foster Care <input type="checkbox"/> DSS Group Home <input type="checkbox"/> Community Residence <input type="checkbox"/> Family Based Treatment Program	<input type="checkbox"/> Crisis/Runaway Shelter <input type="checkbox"/> Family Shelter <input type="checkbox"/> Residential School (SED) <input type="checkbox"/> Residential Treatment Center (DSS) <input type="checkbox"/> Residential Treatment Facility (OMH) <input type="checkbox"/> Psychiatric Inpatient Care <input type="checkbox"/> DFY Facility <input type="checkbox"/> Jail <input type="checkbox"/> Homeless/Streets <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown
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**Single Point of Access/Rockland County Child Referral Form**

**Please specify other family members living in the home with child, if applicable:**

	Age		Name
1. Sibling	<input type="checkbox"/> Male	<input type="checkbox"/> Female	
2. Sibling	<input type="checkbox"/> Male	<input type="checkbox"/> Female	
3. Sibling	<input type="checkbox"/> Male	<input type="checkbox"/> Female	
4. Sibling	<input type="checkbox"/> Male	<input type="checkbox"/> Female	
5. Step-sibling	<input type="checkbox"/> Male	<input type="checkbox"/> Female	
6. Step-sibling	<input type="checkbox"/> Male	<input type="checkbox"/> Female	
7. Step-sibling	<input type="checkbox"/> Male	<input type="checkbox"/> Female	
8. Other Adult	<input type="checkbox"/> Male	<input type="checkbox"/> Female	
9. Other Adult	<input type="checkbox"/> Male	<input type="checkbox"/> Female	

Date of Birth			Age	Gender		US Citizen
				Male <input type="checkbox"/>	Female <input type="checkbox"/>	<input type="checkbox"/> Yes
Month	Day	Year				<input type="checkbox"/> No _____ Alien Registration#

<b><u>RACIAL GROUP</u></b>	
<input type="checkbox"/> 1. Asian <input type="checkbox"/> 2. Black/African American <input type="checkbox"/> 3. Caucasian <input type="checkbox"/> 4. Hispanic /Latino <input type="checkbox"/> 5. Native American/Alaska Native <input type="checkbox"/> 6. Other _____ <input type="checkbox"/> 7 Unknown	<b>IF HISPANIC/LATINO:</b> <input type="checkbox"/> 1. Puerto Rican <input type="checkbox"/> 2. Dominican <input type="checkbox"/> 3. Cuban <input type="checkbox"/> 4. Mexican <input type="checkbox"/> 5. Guatemalan <input type="checkbox"/> 6. Columbian <input type="checkbox"/> 7. Unknown <input type="checkbox"/> 8. Other: _____

CHILD'S PRIMARY LANGUAGE	PARENTS ABILITY TO SPEAK ENGLISH
<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Creole <input type="checkbox"/> Yiddish <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown	<input type="checkbox"/> Excellent <input type="checkbox"/> Fair <input type="checkbox"/> Poor  If not English, parent's primary language is: _____

**EDUCATIONAL SITUATION**

<b>SCHOOL DISTRICT:</b>	
<b>NAME OF SCHOOL:</b>	
<b>GRADE LEVEL:</b>	
<b>SCHOOL CONTACT PERSON:</b>	
<b>SCHOOL PHONE NUMBER:</b>	
<b>IQ LEVEL:</b>	



**Single Point of Access/Rockland County Child Referral Form**

**Indicate Level of Academic Functioning:**

<input type="checkbox"/> No Academic Problems	<input type="checkbox"/> Functions Below Grade Level	<input type="checkbox"/> Has Been Retained In Grade Level
<input type="checkbox"/> Functions Above Grade Level	<input type="checkbox"/> Receives Special Education Services	<input type="checkbox"/> Other (specify) _____

**Does this child have a condition, which is classified by the Committee Of Special Education?**

<input type="checkbox"/> Emotionally Disturbed	<input type="checkbox"/> Multiple Disabilities	<b>Is there a CSE Pending?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Learning Disabled	<input type="checkbox"/> Deaf/Hard of Hearing	
<input type="checkbox"/> Sensory Impaired	<input type="checkbox"/> Section 504	
<input type="checkbox"/> Autism	<input type="checkbox"/> Visually Impaired	
<input type="checkbox"/> Mental Retardation	<input type="checkbox"/> Orthopedic Impairment	
<input type="checkbox"/> Speech & Language	<input type="checkbox"/> Other (specify) _____	
<input type="checkbox"/> Other Health Impairment	<input type="checkbox"/> Not Classified	
<input type="checkbox"/> Multiple Handicapped	<input type="checkbox"/> Hx. of Classification	

**Please indicate school behavior (select all that applies):**

<input type="checkbox"/> Does not Participate	<input type="checkbox"/> Has Failing Grades	<input type="checkbox"/> Fights with Peers
<input type="checkbox"/> Has Truancy/Attendance Problems	<input type="checkbox"/> Does Not Respond to Teachers/Demands	<input type="checkbox"/> Others (Specify) _____
<input type="checkbox"/> Cuts Classes	<input type="checkbox"/> Lacks Friends @ School	

**CHILD'S HOBBIES AND ACTIVITIES (EX: SPORTS, AFTER SCHOOL PROGRAMS, COMPUTERS)**

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**PLEASE LIST CHILD'S STRENGTHS & RESILENCY FACTORS (EX: SENSE OF HUMOR)**

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**Single Point of Access /Rockland County Child Referral Form**

**REFERRAL SOURCE:**

<b>REFERRED BY:</b>	
<b>TITLE/RELATIONSHIP:</b>	
<b>FACILITY/ORGANIZATION/AGENCY:</b>	
<b>ADDRESS:</b>	
<b>PHONE:</b>	
<b>FAX:</b>	

<b>HAS THE CHILD EVER BEEN HOSPITALIZED FOR PSYCHIATRIC ILLNESS?</b>	<b>IF YES, INDICATE WHERE (IF KNOWN):</b>	<b>IF YES, SPECIFY THE MOST RECENT DATES:</b>	<b>OVERALL # OF HOSPITALIZATIONS:</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	_____		

<b>HAS CHILD EVER BEEN TAKEN TO CRISIS PSYCHIATRIC ER?</b>	<b>HOW MANY TIMES HAS THE CHILD BEEN TAKEN TO CRISIS/PSYCHIATRIC ER WITHIN THE PAST 6-MONTHS?</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

**PLEASE INDICATE THE DEGREE TO WHICH THE CHILD’S BEHAVIOR IS CURRENTLY IMPAIRED DUE TO EMOTIONAL DISTURBANCE IN EACH OF THE FOLLOWING:**

	<b>NOT EFFECTED</b>	<b>MILD IMPAIRMENT</b>	<b>MODERATE IMPAIRMENT</b>	<b>SEVERE IMPAIRMENT</b>
<b>Self Care (adequate personal hygiene &amp; ability to perform age appropriate chores &amp; tasks)</b>				
<b>Social Relationships (ability to establish &amp; maintain relationships with peers &amp; adults)</b>				
<b>Family Life</b>				
<b>Self direction (behavioral controls, decision making, judgment &amp; value system)</b>				



**Single Point of Access/Rockland County Child Referral Form**

<b>How long has the Mental Health problem (s) existed?</b> <input type="checkbox"/> Less than 1-year <input type="checkbox"/> 1-year or more <input type="checkbox"/> Unknown
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Please indicate the degree to which the child’s behavior is currently impaired due to any of the following:

	No Evidence	Current Evidence	Past History	Unknown
Significant Psychotic symptoms (hallucinations & delusions)				
Suicidal Symptoms (attempts, ideation)				
Sexually abused				
Physically abused				
Physical/medical/neglect Psychological or Social neglect				
Self –Destructive Behavior				
At-risk of psychiatric placement or other out of placement due to emotional disturbance				
At risk of causing personal injuries or significant property damage				
Other (specify:)				



**Single Point of Access /Rockland County Child Referral Form**

Please indicate the degree to which the child exhibits the following symptoms or behaviors, which are attributed to an emotional disorder:

	Not Present	Mild	Moderate	Severe	Unknown
<b>Depressed Mood</b>					
<b>Anxiety Nervousness</b>					
<b>Suicidal Symptoms (attempts, threats or ideation)</b>					
<b>Mood Swings</b>					
<b>Anger/temper/tantrums</b>					
<b>Hyperactivity Impulsiveness</b>					
<b>Aggressiveness (physical)</b>					
<b>Irritability/Argumentative</b>					
<b>Psychotic Symptoms</b>					
<b>Obsessive Compulsive</b>					
<b>Sleep Problems</b>					
<b>Elimination Problems (Bowel/bladder)</b>					
<b>Eating Problems</b>					
<b>Phobias/Fears</b>					
<b>Cruelty to Animals</b>					
<b>Fire Setting</b>					
<b>Sexually Acting out</b>					
<b>Antisocial/delinquent</b>					
<b>Cutting/Self Abusive</b>					
<b>Substance Abuse (specify)</b>					
<b>Alcohol Abuse</b>					

Please indicate the nature and degree of other disabilities:

	Not Present	Mild	Moderate	Severe	Unknown
<b>Developmental Delays</b>					
<b>Learning Disability</b>					
<b>Physical Handicap</b>					
<b>Blind Visually Impaired</b>					
<b>Deaf/Hard of Hearing</b>					
<b>Medical Condition</b>					
<b>Other (specify)</b>					

<b>Current Treating:</b>	<b>Clinician</b>	<b>Psychiatrist</b>
<b>Name:</b>		
<b>Facility/Organization/Agency:</b>		
<b>Address:</b>		
<b>Phone Number:</b>		



**Single Point of Access /Rockland County Child Referral Form**

**Current Psychiatric Diagnosis based on DSM IV Diagnosis and Code (both is needed please):**

AXIS	DIAGNOSIS	DSM IV CODE					
Axis I					.		
Axis I					.		
Axis I					.		
Axis II					.		
Axis III					.		
Axis IV					.		
Axis V GAF					.		

**Please indicate Medications for Mental Health Disorder:**

CURRENT MEDICATION (please include dosage)	PAST MEDICATION (within 1-year)

**Please indicate Medications for Non-Mental Health Disorder:**

CURRENT MEDICATION (please indicate dosage)	PAST MEDICATION (within 1-year)

**Please indicate physical health conditions:**

<b>Allergies:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Specify:</b>
<b>Drug Sensitivities:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Specify:</b>
<b>Chronic Health Problems:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Specify:</b>
<b>Other Physical Problems:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Specify:</b>



**Single Point of Access/Rockland County Child Referral Form**

**Please Indicate Current/Previous Mental Health/Community Services:**

	<b>Currently Receiving Services</b>	<b>History of Receiving Services</b>	<b>Never Had Services</b>	<b>Unknown</b>
Inpatient Hospitalization				
Residential Treatment Facility				
Community Residence				
Intensive Day Treatment				
Clinic				
Intensive Case Management/CAFE				
Supportive Case Management				
Home & Community Based Waiver				
Respite				
After-School Program				
Recreation Clubs				
Family Functional Therapy				
Speech and Language Services				
Substance Abuse Program				
School Placement				
Youth Employment Bridges				
PINS/Probation				
CSSI/Network				
Child Protective Services				



**Single Point of Access/Rockland County Child Referral Form**

<b>Community &amp; Mental Health Services</b>	<b>Currently Receiving Services</b>	<b>History of Receiving Services</b>	<b>Never Had Services</b>	<b>Unknown</b>
<b>Foster Care</b>				
<b>Preventive Services</b>				
<b>Big Brother/Sister Mentoring</b>				
<b>OCFS Placement</b>				
<b>School Placement</b>				
<b>DSS Placement (RTC)</b>				
<b>Other (Specify)</b>				

**Child's Pediatrician (If child qualifies for Waiver Services, an updated physical is needed)**

<b>Name</b>	
<b>Agency</b>	
<b>Phone Number</b>	
<b>Fax Number</b>	
<b>Date of Last Physical</b>	

**Active Community Contact For Child and Family**

<b>Name</b>	
<b>Agency</b>	
<b>Phone Number</b>	
<b>Fax Number</b>	

<b>Name</b>	
<b>Agency</b>	
<b>Phone Number</b>	
<b>Fax Number</b>	

<b>Name</b>	
<b>Agency</b>	
<b>Phone Number</b>	
<b>Fax Number</b>	

<b>Name</b>	
<b>Agency</b>	
<b>Phone Number</b>	
<b>Fax Number</b>	

<b>Name</b>	
<b>Agency</b>	
<b>Phone Number</b>	
<b>Fax Number</b>	





**COUNTY OF ROCKLAND DEPARTMENT OF MENTAL HEALTH  
ROCKLAND COUNTY CHILDREN'S SINGLE POINT OF ACCESS**

**PARENT OR GUARDIAN QUESTIONNAIRE**

Name of Parent/Guardian: \_\_\_\_\_ Child's Name: \_\_\_\_\_

**It is important that you get the services and supports you and your child need. Please take a few minutes to think about your family's needs and complete the questions below. It is helpful to be as specific as possible. Thank you.**

**What are your child's strengths?**

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**What are your family's strengths?**

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**What is your biggest concern right now?**

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**What would make things better for your child and family?**

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**Do you have any additional comments?**

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