All youth identified as requiring intensive mental health services in New York City (NYC) are to be referred to the NYC Department of Health and Mental Hygiene's Children's Single Point of Access (CSPOA). Intensive mental health services include the following: **Home and Community Based Services (HCBS) waiver, ages 5–21, Community Residence (CR), ages 5–17 and Non-Medicaid Care Coordination, ages 0–21. Also, CSPOA can facilitate referrals for Health Home Care Management, ages 0–21, for children not currently in foster care.** *For more information or any questions you may have regarding this application, please call your local CSPOA office at 347-396-7205.*

Referral Process:
In an effort to facilitate the referral process, please provide a completed Universal Referral Form (URF), a reason for referral (including the youth and family's needs and strengths), and required clinical materials. Upon receipt, the referral will be reviewed for completeness. NYC CSPOA will make an assessment, determine eligibility, and assign the case to the appropriate level of care. Please submit the documentation to the NYC CSPOA office.

NYC Children's Single Point of Access
NYC Department of Health and Mental Hygiene
Bureau of Children, Youth & Families
42-09 28th Street
Long Island City, NY 11101

Assessments Required (All referral packets must be typed or written legibly)

(1) Psychosocial Assessment
This assessment should be completed within the past **12 months** and document the following information about the child:

- Developmental history and milestones
- Current living environment
- Family dynamics
- Education
- Emotional factors
- Involvement with the court system, if applicable

If the application is for a CR, then the psychosocial assessment must be current within 90 days and, completed by a master's level human services professional.

(2) Psychiatric Assessment
The psychiatric assessment must be current within **12 months** and completed by an **M. D.,** a **D.O.** or a **Psychiatric Nurse Practitioner. If the request is for a CR, it must be current within 90 days or newer.**

The psychiatric assessment must include:

- Child's current mental health status
- DSM-5 diagnosis and ICD-10 code
- History of prior psychiatric care and course of treatment (including dates and length of stay)
- History of psychotropic medications (if any) and the child's response
- Discharge summary (i.e., outpatient appointment clinic, date, time, etc.)

3) Physical/Medical Assessment
This assessment must be current within the past **12 months** and completed by an **M.D.**, a **D.O.**, a **P.A.** or a **Nurse Practitioner. If the application is for a CR, 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 and 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 NYC CSPOA office.

Universal Referral Form (URF): New York City CSPOA

For Admin Use Only: CSPOA ID#_____

□ Bronx □ Manhattan □ Brooklyn □ Queens □ Staten Island

Date of Referral _____ / _____ / _____

Client Information:

Child's Name (Last, First, Middle Initial):_____

Date of Birth: ____ / _____/ _____ Gender: Male/Female Social Security Number: _____

Medicaid: Yes / No (please circle one)

If applying for an HCBS waiver or CR, please note that both services require Medicaid enrollment. Immigration status may impact a child's ability to apply for and receive Medicaid coverage. CSPOA specialists will review eligibility requirements with referral sources after the referral has been processed and assigned for assessment and review.

Current Address: _____Apt #: _____ City: _____ State: ____ ZIP Code: _____

Phone #: (____) _____ Alternate Phone #: (____) _____

Parent/Guardian Name(s): _____

Referral Source

Type of Referral Source:

□Family/Legal Guardian □School/Education System □Residential Treatment Facility (OMH)

□Family Based Therapeutic Intervention □Community Residence (CR) □Functional Family Therapy (FFT)

□HCBS Waiver □Care Management □Day Treatment

□Home Based Crisis Intervention □Acute Psychiatric Inpatient □State Psychiatric Inpatient

□Outpatient Mental Health Clinic □Residential Treatment Center (ACS/CSE) ACS/Foster Care

□ACS/Therapeutic Foster Boarding Home □ACS/Preventive Program □ Drug Treatment Program (In/Out Patient)

□Other (specify): _____

Referral Source: _____Address: _____City: _____
State: ____ ZIP Code: _____
First Contact: _____ Email: _____
Phone #: _____ Fax #:_____
Second Contact: _____
Email: _____
Phone #: _____ Fax#:_____

Types of Services Referred for:

□Health Home Care Management □Non-Medicaid Care Coordination

□HCBS Waiver □Community Residence

Signature of person completing the URF: _____

Title	Print Name	Date
_____	_____	_____

Demographic Information

What is the child's ethnicity or race?
☐Hispanic ☐White ☐Black ☐Asian/Pacific Islander ☐Native American/Alaskan
Other (specify): _____ Primary language of child: _____

Is parent or guardian fluent in English? _____ If not, which language do they prefer to speak? _____

Financial and Insurance Information

Type of Health Coverage:
If child has **Regular Medicaid (including Foster Care Medicaid)**, provide Medicaid ID #: _____

If child has **Managed Care Medicaid**, provide name of HMO _____ ID #: _____
Medicaid Status: ☐Eligible ☐Application Pending ☐Not Applied ☐Ineligible

☐Private, third-party coverage payer _____ ☐None

☐Other (specify): _____

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

If **yes**, how much money does they receive on a monthly basis? ☐Over $785 ☐Under $785

Current Living Situation

☐Independent Living
☐Parent(s)
☐Relative's Home
☐Foster Care
☐Community Residence (CR)
☐ACS Group Home
☐Therapeutic Foster Boarding Home
☐Crisis Shelter
☐Homeless Shelter
☐Education Residential Placement (CSE)
☐Residential Treatment Center (ACS)
☐Residential Treatment Facility (OMH)
☐State Psychiatric Inpatient
☐Acute Psychiatric Inpatient
☐Jail
☐Homeless/Streets or Abandoned Building
☐Other (specify) _____

Court Involvement

Does the applicant have any known court involvement? Yes / No (please circle one)
(Complete if not included in the psychosocial assessment)

If known, please describe:
_____
_____
_____

Child's Educational Placement

Select one response:
☐Regular Education ☐Special Education (refer to CSE Classification) ☐Day Treatment

☐Partial Hospitalization Program ☐Resident School Placement (CSE) ☐Vocational Training Only

☐Part-Time Vocational/Educational ☐Not Enrolled in School ☐High School Graduate/GED

☐Other (specify): _____

Current School Classification (i.e., 12:1): _____ Current Grade: _____

Please select one answer for the following questions:

Caregiver's Strengths:	Yes	No	Limited
Caregiver has the capacity to provide appropriate guidance and discipline for the child.	☐	☐	☐
Caregiver actively participates in the planning and provision of the child's care.	☐	☐	☐
Caregiver understands and accepts the child's condition and the reasons for treatment.	☐	☐	☐
Caregiver exhibits the ability to manage the household to support the child's care and related activities.	☐	☐	☐
Caregiver has the financial and social assets available to assist the child's care.	☐	☐	☐
Caregiver is able to provide a stable living environment for the child, both presently and in the foreseeable future.	☐	☐	☐
Caregiver is able to provide a stable living environment for the child, as free from harmful elements as possible, such as neglect, drugs, violence, etc.	☐	☐	☐
Caregiver is able to assume caretaking responsibilities without the following challenges: medical, physical, mental health or substance abuse.	☐	☐	☐

Child's Strengths:	Yes	No	Limited
Child exhibits appropriate social skills with both peers and adults.	☐	☐	☐
Child is able to maintain significant relationships with family members and other significant individuals.	☐	☐	☐
Child exhibits the ability to adapt and maintain appropriate behavior in different environments and situations in their life.	☐	☐	☐
Child is in an appropriate educational setting that meets academic, emotional and cognitive needs.	☐	☐	☐
Child and family are involved in spiritual or religious activities that offer support.	☐	☐	☐

Education Assessment: For CR applications, please fill out the following section. If an Individualized Education Program (IEP) form has been completed within the last 12 months, please attach it. If an IEP is included with this application, this section does not need not to be completed. If applicant is not applying for CR, please indicate that this section is "Not Applicable."

Reading level: _____

Math level: _____

Date of last IEP (if any): _____

Is the child currently attending school? If no, why not? _____

_____

_____

Current school placement and address:

_____

_____

Behavior in class:

_____

_____

Academic strengths and challenges:

_____

_____

What academic environment would best meet the needs of the child?

_____

_____

Overall grade level functioning:

_____

_____

Recommendations:

_____

_____

Addendum for Children Known to the Administration for Children's Services
(Information must be completed for children in foster care receiving Child Protective Services, Preventive Services and Voluntary Placements)

ACS Case #: _____

Please explain the child's and family's involvement in foster care services:

_____

_____

_____

Has this child been considered for the Bridges to Health (B2H) waiver? ☐Yes ☐No

If yes, what is the status? If no, please explain:

_____

_____

_____

Please provide the following information (as applicable):

Foster Care/Preventive Services Agency: _____

Case Planner/Child Protective Specialist (Last, First): _____ Unit #: _____
Phone #: _____

Supervisor (Last, First): _____
Phone #: _____

Case Manager (Last, First):_____
Phone #: _____

CES Worker (if applicable) (Last, First): _____
Phone #: _____

Has a progress note from Connections been submitted for this change of placement level? ☐Yes ☐No
(Note: Only necessary for children living in foster care)
If **NO**, please explain: _____

_____

_____

Has a change in Level of Care been approved by ACS? ☐Yes ☐ No

If YES, please submit copy.

If **NO**, please explain:

_____

_____

_____