Eligibility Criteria for High End Mental Health Services

The following services serve youngsters ages 5-17.9 who suffer from serious emotional disturbance or behavioral disorders that are interfering with his/her functioning in the community. The youngster may also be at risk for being hospitalized, re-hospitalized, or requiring residential placement.

Home and Community Based Services Waiver (HCBS) Waiver

Home and Community Based Services Waiver program is designed to serve youngsters to remain at home; even when the youngster’s mental health needs make him or her eligible for placement in a residential treatment facility or intermediate inpatient care. Services are tailored to meet the needs of the youngster and family. Services may include: respite care, intensive in home services, skill building services, family support, and crisis response services.

Intensive Case Management (ICM)

Intensive Case Management program provides a specially trained child mental health specialist who works with the youngster and family. The specialist identifies the families needs, coordinates all of the different supports and services necessary to keep the youngster at home. The goals of the program are to lessen the need for inpatient admission, to shorten residential placement and to avoid unnecessary emergency room visits.

Blended Case Management (BCM)

Blended Case Management program is a team approach to case management services that combines the caseloads of Intensive Case Managers (ICMs) and Supportive Case Managers (SCMs). Services are tailored to the needs rather than imposing a single model of service intensity. Youngsters can fluctuate between “intensive” and “supportive” levels of service as needed without severing ties with familiar case managers.

Community Residence (CR)

Community Residences (CR) are small therapeutic group homes. Licensed by the NYS Office of Mental Health, that serves 6 to 8 children who live with and are supervised by specially trained staff. Children are placed in a residence as close to their homes as possible. Services include structured daily living activities and training in problem solving skills. Clinical services are provided by local mental health programs.

Family Based Therapeutic Intervention (FBTI)

Family Based Therapeutic Intervention (FBTI) program is designed to stabilize families through the use of evidence based family therapy techniques. Trained mental health professionals provide caretakers with clear strategies to accomplish specific goals and improve functioning. FBTI is typically provided in conjunction with Case Management Services and is not generally a stand-alone service.

Updated May 13, 2013
All youth identified as requiring Intensive Mental Health services in New York City are to be referred to the Child and Family Institute at St. Luke’s and Roosevelt Hospitals’ Children’s Single Point of Access (CSPOA). Intensive Mental Health Services include the following: (Home and Community Based Services Waiver; Intensive, Supportive and Blended Case Management; Community Residence; Family Based Therapeutic Intervention). For more information, or any questions you may have regarding this application, please call your local CSPOA office at: (888) CSPOA-58.

Referral Process:
In an effort to facilitate the referral process, please provide a completed Universal Referral Form, 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. New York City CSPOA will make an assessment, determine eligibility, and assign the case to the appropriate level of care. Please submit the documentation to one of the corresponding CSPOA Offices.

Bronx/Manhattan CSPOA:  
St. Luke’s and Roosevelt Hospitals  
Child and Family Institute  
1090 Amsterdam Avenue, 15th Floor  
New York, New York 10025  
Fax: (212) 636-1627

Brooklyn/Queens/Staten Island CSPOA:  
St. Luke’s and Roosevelt Hospitals  
Child and Family Institute  
185 Montague Street, 11th Floor  
Brooklyn, NY 11201  
Fax: (718) 722-9203

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

(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), 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

(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), it must be current within 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 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 or a Nurse Practitioner. If the application is for a Community Residence (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 50-69. 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.

Updated May 13, 2011
# Universal Referral Form (URF): New York City CSPOA

**For Admin Use Only:** CSPOA ID# __________

**Updated May 13, 2011** – Please call (888) CSPOA-58 if you need assistance with this form.

<table>
<thead>
<tr>
<th>□ Bronx</th>
<th>□ Manhattan</th>
<th>□ Brooklyn</th>
<th>□ Queens</th>
<th>□ Staten Island</th>
</tr>
</thead>
</table>

**Date of Referral** ________ / ________ / ________

### Client Information:

- **Child’s name** *(Last, First, MI)* ____________________________

- **DOB** ________ / ________ / ________
- **Gender**: Male/Female
- **Social Security#** ____________________________

- **Youngster is a Citizen**: Yes/No (please circle)

- **What is Child’s Residence Status?** ____________________________

- **Current Address** ____________________________
- **Apt #** ________
- **City** ____________________________
- **State** ________
- **Zip** ________

- **Phone #** (____) ____________________________
- **Alternate #** (____) ____________________________

- **Parent(s) name(s) and address (if different from youngster’s):** __________________________________________________________

### Referral Source

- **Type of Referral Source**

  - □ Family/Legal Guardian
  - □ School/Education System
  - □ Residential Treatment Facility (OMH)
  - □ Family Based Therapeutic Intervention
  - □ Community Residence
  - □ Functional Family Therapy (FFT)
  - □ HCBS Waiver
  - □ Case Management
  - □ Day Treatment
  - □ Home Based Crisis Intervention
  - □ Emergency Room
  - □ Juvenile Justice System
  - □ Education Residential Placement (CSE)
  - □ Acute Psychiatric Inpatient
  - □ State Psychiatric Inpatient
  - □ Outpatient Mental Health Clinic
  - □ Residential Treatment Center (ACS)
  - □ 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** ________

- **Contact Person** ____________________________________________
- **Second Contact (2)** ____________________________________________

- **Phone #** ____________________________
- **Fax #** ____________________________
- **Phone #(2)** ____________________________
- **Fax#(2)** ____________________________

### Types of services referred for:

- □ Supportive Case Management
- □ Intensive Case Management
- □ Blended Case Management
- □ HCBS Waiver
- □ Community Residence
- □ Family Based Therapeutic Intervention (Bronx Only)

### Signature of person completing the Universal Referral Form

- **Signature/Title** ____________________________________________
- **Print Name** ____________________________________________
- **Date** __________
Demographic Information
What is the child’s race/ethnicity?
- Hispanic
- White
- Black
- Asian/Pacific Islander
- Native American/Alaskan
Other (specify) ____________________________
Primary Language of Child ____________________________
Is Caregiver/Guardian fluent in English? ________________
If not, which language? ____________________________

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 payor ____________________________
- 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 he/she receive on a monthly basis?
- Over $761
- Under $761

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

Court Involvement: Does the Applicant have any known court involvement? Yes/No
(complete if not included in Psychosocial)
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: ___________

Updated May 13, 2011 –Please call (888) CSPOA-58 if you need assistance with this form.
### Caregiver’s Strengths:

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Limited</th>
</tr>
</thead>
<tbody>
<tr>
<td>The caregiver has the capacity to provide appropriate guidance and discipline for the child.</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>The caregiver actively participates in the planning and provision of the child’s care.</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>The caregiver understands and accepts the child’s condition and the reasons for treatment.</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Caregiver exhibits the ability to manage the household to support the child’s care and related activities.</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Caregiver has the financial and social assets available to assist the child’s care.</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>The caregiver is able to provide a stable living environment for the child, both presently and in the foreseeable future.</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Caregiver is able to provide a stable living environment for the youngster as free from harmful elements as possible, such as neglect, drugs, violence, etc.</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Caregiver is able to assume care taking responsibilities without the following challenges i.e., medical, physical, mental health, and substance abuse.</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

### Child’s Strengths

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Limited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child exhibits appropriate social skills with both peers and adults.</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Child is able to maintain significant relationships with family members and other significant individuals.</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Child exhibits the ability to adapt and maintain appropriate behavior in different environments and situations in their life.</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Child is in an appropriate educational setting that meets academic, emotional, and cognitive needs.</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Child and family are involved in spiritual or religious activities that offer support.</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>
### Education Assessment

For applications to Out of Home Services, please fill out the following section. If an IEP has been completed within the last 12 months, please attach it. If an IEP is included with this application, this section need not be completed.

<table>
<thead>
<tr>
<th>Reading Level:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Math Level:</td>
<td></td>
</tr>
</tbody>
</table>

Date of Last IEP (if any):  _______________

Is the child currently attending School? If not, why?  ______________________________________________________________

Current School Placement and Address:  ______________________________________________________________

Behavior in Class:  ______________________________________________________________

Academic Strengths and Challenges:

-  ______________________________________________________________
-  ______________________________________________________________
-  ______________________________________________________________
-  ______________________________________________________________
-  ______________________________________________________________
-  ______________________________________________________________
-  ______________________________________________________________
-  ______________________________________________________________

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

-  ______________________________________________________________
-  ______________________________________________________________

Over all grade level functioning:

-  ______________________________________________________________

Recommendations:

-  ______________________________________________________________
**Addendum for Children Known to ACS**  
(Information must be completed for children in Foster Care, receiving Child Protective Services, Preventive Services and Voluntary Placements)

<table>
<thead>
<tr>
<th>ACS Case #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please explain the child’s/family’s involvement in Foster Care Services</td>
</tr>
<tr>
<td></td>
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<tr>
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<td></td>
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<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
| 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 (Please submit Copy)? | □ Yes □ No  
| If NO, please explain: |  
| |  
| |  
| |  
| |  
| |  

Updated May 13, 2011 –Please call (888) CSPOA-58 if you need assistance with this form.
St. Luke's and Roosevelt Hospitals

AUTHORIZATION FOR RELEASE OF INFORMATION

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:

I consent to release information to St. Luke's and Roosevelt Hospitals' Child and Family Institute New York City's Children's Single Point of Access (CSPOA) to review this referral for intensive mental health services. I have read this complete document and consent to have released the Universal Referral Form, educational, medical and mental health assessments, including: psychiatric and psychological evaluations, psycho-social assessments and discharge reports. I also consent for CSPOA to contact me, in addition to the referral source, including the writers of the evaluations to discuss treatment for my child. I understand that CSPOA may share this information and clinical material with a variety of agencies and organizations that are contracted through the New York State Office of Mental Health and/or the New York City's Department of Health and Mental Hygiene. Services may include the following: Home and Community Based Services Waiver, The Family Based Therapeutic Intervention Program (FBTI), Case Management and Community Residence. In addition, referrals may be discussed with and provided to the following agencies/programs: Office of Persons with Developmental Disabilities, the Parent Resource Center, Intensive Crisis Stabilization and Treatment, Home Based Crisis Intervention, FRIENDS VNS Community Mental Health Services, Functional Family Therapy (FFT), the Office of Children & Family Services, the Department of Social Services, and Pre-Admission Certified Committee. I understand that I have the right to cancel my permission to release the information or withdraw from the referral process at any time by contacting the New York City's CSPOA Administrative Office at 1-888-277-6258.

Purpose or Need for Information:

1. This information is being requested:
   - by the individual or his/her personal representative; or
   - Other (please describe)

2. The purpose of the disclosure is (please describe):

   It is understood that this information will be used to evaluate ______________ for possible placement with HCBS Waiver, Case Management, Community Residence, Family Based Therapeutic Intervention and/or other support services as mentioned above in the Description. Upon acceptance, my child will be receiving services from one of the above.

A. I authorize the New York City's Children's SPOA to release clinical information and make recommendations for the appropriate program for possible enrollment. I hereby permit the use and/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 cannot 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 Children's Intensive Mental Health Services. I am aware that 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§164.524.
**AUTHORIZATION FOR RELEASE OF INFORMATION**

**B. Periodic Use/Disclosure:** I hereby permit the periodic use/disclosure of the information described above to the person/organization/facility/program identified above as necessary to fulfill the purpose identified above. I hereby understand that I have the right to revoke my authorization to release information by writing the New York City Children’s Single Point of Access at:

NYC Children’s Single Point of Access  
Children’s Community Mental Health Services  
Child and Family Institute  
St. Luke’s and Roosevelt Hospitals  
1090 Amsterdam Avenue, 15th Floor  
New York New York 10025

I understand that this authorization will expire when I am no longer receiving one of the intensive high-end mental health services.

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

<table>
<thead>
<tr>
<th>Signature of Patient or Personal Representative</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient's Name (Printed)</td>
<td></td>
</tr>
<tr>
<td>Personal Representative's Name (Printed)</td>
<td></td>
</tr>
<tr>
<td>Description of Personal Representative's Authority to Act for the Patient (required if Personal Representative signs Authorization)</td>
<td></td>
</tr>
</tbody>
</table>

**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:

<table>
<thead>
<tr>
<th>Staff person's name and title</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Authorization Provided To</td>
<td></td>
</tr>
<tr>
<td>Date</td>
<td></td>
</tr>
</tbody>
</table>

**To be Completed by Facility:**

<table>
<thead>
<tr>
<th>Signature of Staff Person Using/Disclosing Information</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Title</td>
<td></td>
</tr>
<tr>
<td>Date Released</td>
<td></td>
</tr>
</tbody>
</table>

**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:

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

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</tr>
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</table>

Updated 10/3/2013
AUTORIZACION PARA DIVULGAR INFORMACION

De acuerdo con las leyes y reglamentos estatales y federales, el paciente o su representante tienen que llenar esta autorización para el uso/divulgación de información relacionada con su salud. Se necesitará otra autorización para el uso de información confidencial referente al Virus de Inmunodeficiencia Adquirida (VIH)

PARTE 1: Autorización para divulgar información

Descripción de la información que se usará/divulgará:

Yo autorizo a St. Luke’s and Roosevelt Hospital y al Child and Family Institute de la Ciudad de Nueva York para que divulguen mi información. Asimismo, autorizo a Children’s Single Point of Access (CSPOA) para que revise esta solicitud de servicios intensivos de salud mental. La información que yo autorizo que se divulgue incluye el Documento Universal de Recomendaciones (Universal Referral Form), expedientes educativos, evaluaciones médicas, evaluaciones de salud mental, incluyendo evaluaciones psiquiátricas, evaluaciones psicológicas, evaluaciones psico-sociales y informes de dada de alta. Yo he revisado toda la solicitud y autorizo a que CSPOA me contacte y que contacte a los autores del referido y de las evaluaciones. Yo entiendo que se podrán dar referidos a agencias/programas que tienen contratos con la Oficina de Salud Mental de Nueva York y/o el Departamento de Salud y Salud Mental del la Ciudad de Nueva York. Los servicios podrían incluir lo siguiente: Home and Community Based Services Waiver, Case Management, Family Based Therapeutic Intervention y Community Residence. Además se podrán dar referidos a las siguientes agencias/programas: Office of Persons with Developmental Disabilities, the Parent Resource Center, Intensive, Crisis Stabilization and Treatment, Home Based Crisis Intervention, FRIENDS VNS Community Mental Health Services, Functional Family Therapy (FFT), Departamento Social de Servicios Locales y Pre-Admission Certified Committee. Entiendo que, en caso de que decida retirarme del proceso de recomendaciones, tengo el derecho de cancelar el permiso para divulgar mi información poniéndome en contacto con la Oficina administrativa del CSPOA de la Ciudad de Nueva York 1-888-277-6258.

Motivo para la Solicitud de la información:

1. Esta información la solicita:
   - El individuo o su representante legal; o
   - Otro (por favor, indíquelo) ____________________________

2. El motivo de la divulgación es (por favor describalo):

Entiendo que esta información se utilizará para evaluar a _________________ para su posible incorporación al HCBS Waiver, Case Management, Family Based Therapeutic Intervention y Community Residence y otros servicios de apoyo como fue mencionado anteriormente. Al aceptar, mi niño recibirá servicios por parte de alguno de los mencionados anteriormente.

A. Autorizo a SPOA de los Niños de la Ciudad de Nueva York a que divulgue información clínica y haga recomendaciones sobre la posible incorporación al programa adecuado. Doy permiso para el uso y divulgación de la información anteriormente mencionada a la Persona/Organización/Institución/Programa(s) identificadas anteriormente. Entiendo que:

   1. Solamente esta información puede ser usada o divulgada como resultado de esta autorización.
   2. Esta información es confidencial y, legalmente, no puede ser dada a conocer sin mi permiso.
   3. Si esta información se le diera a alguien que no esté obligado a regirse por los reglamentos federales sobre protección de la privacidad, la información no estará protegida.
   4. Tengo el derecho de anular esta autorización en cualquier momento. Si así lo decido, tendrá que ser por escrito utilizando el formato que me de (coloque el nombre de la institución/programa) Servicios Intensivos de Salud Mental para Niños. Es de mi conocimiento que esta anulación no tendrá efecto si las personas a las que he autorizado a usar o a divulgar mi información de salud ya han iniciado acciones debido a mi autorización anterior.
   5. No tengo que firmar esta autorización, y si me rehúso a hacerlo, esto no tendrá ningún efecto sobre mis posibilidades de recibir tratamiento y tampoco afectará mis posibilidades de calificar para recibir prestaciones por parte de la Oficina de Salud Mental del Estado de Nueva York.
   6. Tengo el derecho de ver y copiar mi información de salud que será usada o divulgada de acuerdo con lo reglamentos federales sobre protección de la privacidad 45 CFR_164524.

Continúa en la página siguiente ☞

Updated 10/3/2013
**AUTORIZACION PARA DIVULGAR INFORMACION**

### B. Uso periódico/Divulgación:

Autorizo a que la información descrita anteriormente se use o se de a conocer a la persona/organización/institución o programa mencionado anteriormente. Entiendo que puedo revocar mi autorización escribiendo a el Children’s Single Point of Access (CSPOA) a la siguiente dirección.

NYC Children’s Single Point of Access  
Children’s Community Mental Health Services  
Child and Family Institute  
St. Luke’s and Roosevelt Hospitals  
1090 Amsterdam Avenue, 15th Floor  
New York New York 10025

Mi autorización vencerá cuando ya no reciba más servicios de salud mental intensivos.

### C. Firma del paciente:

Yo certifico que autorizo el uso de mi información médica/de salud mental como consta en este documento.

<table>
<thead>
<tr>
<th>Firma del paciente o representante legal</th>
<th>Fecha</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nombre del paciente (En letra de molde)</td>
<td></td>
</tr>
<tr>
<td>Representante legal (En letra de molde)</td>
<td></td>
</tr>
<tr>
<td>Descripción de la autoridad dada al representante del paciente para actuar en lugar del paciente</td>
<td></td>
</tr>
</tbody>
</table>

*Se requiere si el representante firma la autorización*

### D. Declaración del testigo/Firma:

Yo testifico la ejecución de esta autorización y declaro que se le entregó una copia del documento al paciente o a su representante legal.

**FIRMA COMO TESTIGO**  
Nombre y cargo del miembro del personal

<table>
<thead>
<tr>
<th>Autorización otorgada a</th>
<th>Fecha</th>
</tr>
</thead>
</table>

**Para ser llenado por la institución:**

Firma del miembro del personal que divulgará/hará uso de esta información

<table>
<thead>
<tr>
<th>Cargo</th>
<th>Fecha de entrega de la información</th>
</tr>
</thead>
</table>

**PART 2: Revocación de la Autorización para Divulgar Información**

Por medio de la presente, revoco mi autorización para usar/divulgar la información indicada en la parte 1 a la persona cuyo nombre y dirección aparecen a continuación:

<p>| |</p>
<table>
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Por medio de la presente me niego a autorizar el uso/divulgación que se indica en la parte 1, a la persona/organización/institución/programa cuyo nombre y dirección aparecen a continuación:

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
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</table>

<table>
<thead>
<tr>
<th>Firma del paciente o representante legal</th>
<th>Fecha</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nombre del paciente (En letra de molde)</td>
<td></td>
</tr>
<tr>
<td>Nombre del representante legal (En letra de molde)</td>
<td></td>
</tr>
</tbody>
</table>

*Se requiere si el representante firma la autorización*