Children's Single Point of Access Application Part 1

Today's date: ___________

Child's Information			
Full Name (Last, First MI)		Primary Language(s)	
Date of Birth (DOB)	Social Security Number (SSN)	Gender Identity	
Home Address		Fluent in English? ☐ YES ☐ NO	
Mailing Address		Does the child have health insurance? ☐ YES ☐ NO	

**** Please note that some services require Medicaid enrollment. Immigration status may impact a child's ability to apply for and receive Medicaid coverage. ****

Insurance Plan	Insurance Policy Number	Medicaid/Client Identification Number (CIN)

Is this child enrolled in Health Home Care Management? ☐ YES ☐ NO ☐ UNKNOWN	If yes, please indicate which Health Home/Care Management Agency.

Referral Information		
Date of Referral	Name/Title of Referrer	Referring Organization/Program
Address of Referrer		
Referrer Phone	Referrer Fax	Referrer Email
Reason for Referral (Attach additional sheet if needed.)		
Referrer Signature		

Caregiver Contact #1 Information		Caregiver Contact #1 Information	
Full Name		Full Name	
Address		Address	
Phone	Email	Phone	Email
Relationship to Child	Legal Guardian? ☐ YES ☐ NO	Relationship to Child	Legal Guardian? ☐ YES ☐ NO
Caregiver Primary Language	Fluent in English? ☐ YES ☐ NO	Caregiver Primary Language	Fluent in English? ☐ YES ☐ NO

Is this caregiver the primary contact? ☐ YES ☐ NO	Is this caregiver the primary contact? ☐YES ☐NO
Is this caregiver enrolled in Health Home Care Management? ☐ YES ☐ NO ☐UNKNOWN	Is this caregiver enrolled in Health Home Care Management? ☐ YES ☐ NO ☐UNKNOWN
If yes, please indicate which Health Home/Care Management Agency?	If yes, please indicate which Health Home/Care Management Agency?

Legal Custody Status	
☐Both parents together	☐ Joint custody
☐Biological mother only	☐ Department of Social Services (DSS)
☐Biological father only	☐ Adult sibling
☐Other legal guardian (describe):	☐ Emancipated minor
	☐ Adoptive parent

Current Providers	
School and grade	Therapist/Therapist's agency
Psychiatrist/Psychiatrist's agency	Other service provider/agency

IQ Testing Scores (if available)		
Verbal	Full Scale	Test date

Additional Information	
Is the child/youth currently admitted to an inpatient facility? ☐ YES ☐ NO	Number of hospitalizations in the past 12 months
If yes, please indicate the name of the facility and expected discharge.	Number of Emergency Department visits in the past 12 months
Is the child/youth currently receiving DSS preventive services? ☐ YES ☐ NO ☐UNKNOWN	Other systems involvement (e.g. child protective services (CPS), multisystemic therapy (MST), etc.) Please specify.
If yes, please indicate the name of the provider.	

Mental Health Diagnosis (if known)	
Does the child have a diagnosed serious emotional disturbance (SED)? ☐ YES ☐ NO	If so, what is it?
If yes, by whom was the diagnosis made?	If yes, when was the diagnosis made?

Preliminary Eligibility Screening
Does the child have two or more chronic medical conditions (i.e. asthma, diabetes, substance use disorder)? ☐YES ☐NO ☐UNKNOWN
Does the child have HIV/AIDS? ☐YES ☐NO ☐UNKNOWN
Do you believe the child has a SED? (The child meets one of the below criteria.) ☐YES ☐NO ☐UNKNOWN • Difficulty with self-care, family life, social relationships, self-control or learning • Suicidal symptoms • Psychotic symptoms (hallucinations, delusions, etc.) • Is at risk of causing personal injury or property damage • The child's behavior creates a risk of removal from the household
Has the child been exposes to multiple traumatic events that have left a long-term and wide-ranging impact? ☐YES ☐NO ☐UNKNOWN

If you have supporting documentation related to one of the above diagnoses/conditions, please attach it.

Please complete attached REQUIRED consent for release of information to process this SPOA application.