NYS OMH Single Point of Access (SPOA)
Case Management/ACT Program Application Cover Sheet

Send this cover sheet to CUCS along with the complete Universal Referral Form packet for all SPOA applicants.

Date of Submission: _____ For CM/ACT Consultation Assistance call (212) 801-3343

TO:
SPOA Case Management/ACT Program
Center for Urban Community Services
120 Wall Street, 25th Floor
New York, NY 10005
Fax: (212) 803-5880

ALL COMPLETE SPOA PACKETS must include:

- ☐ **This Cover Sheet with Signed Consent**
- ☐ **The Universal Referral Form (URF)**
- ☐ **ACT Referral Summary (if ACT is requested)**
- ☐ **A Comprehensive Psychosocial Summary**
- ☐ **A Comprehensive Psychiatric Evaluation**
- ☐ **Physical Exam (required from inpatient referral)**
- ☐ **TB Test Results (required from inpatient referral)**

FROM:

Referring Agency: _____

Referring Program: _____

Referring Worker's Name: _____

Contact Phone: _____ Fax:_____

Referring Worker E-mail: _____

Borough Where Applicant Is/Will Reside (circle one): Brooklyn Manhattan Queens Bronx Staten Island

RE:

Applicant's Last Name: _____ First Name: _____

Applicant's D.O.B.: _____ / _____ / _____

Level of Service Requested (circle one): ACT ICM BCM SCM

TYPE OF REFERRAL (circle all that apply):

Priority Referral: AOT Potential AOT State PC Acute Inpatient Unit CPEP Unit Psychiatric Emergency Room Correctional Health/Prison Mental Health Unit Mobile Crisis Teams Mental Health Courts OMH Links OMH Residential Treatment Facilities

Community Referral: ACT/Case Management Transfer Continuing Day Treatment Program Psychiatric Outpatient Program Residential Program DHS/Sec 8 Project Other: _____

Specific ACT/Case Management Program Requested (If applicable): _____

CONSENT TO RELEASE INFORMATION

(Please keep original on file)

I authorize the disclosure of the New York City Case Management Application and all related supporting documents to the Center for Urban Community Services, 120 Wall Street, 25th Floor, New York, NY 10005 for the purposes of case management assessment and placement assistance for a period of ninety (90) days. I understand that I may revoke this authorization at any time. My revocation must be in writing. I am aware that my 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.

_____	_____	_____
Applicant's name (printed)	**Signature of Applicant**	**Date**
_____	_____	_____
Witness' name (printed)	**Signature of Witness**	**Date**