COUNTY OF SUFFOLK

STEVEN BELLONE
SUFFOLK COUNTY EXECUTIVE

DEPARTMENT OF HEALTH SERVICES
JAMES L. TOMARKEN, MD, MPH, MBA, MSW
COMMISSIONER

DIVISION OF COMMUNITY MENTAL HYGIENE SERVICES
ANN MARIE CSORNY, LCSW
DIRECTOR

ADULT SPOA
DESCRIPTION OF SERVICES

CARE COORDINATION:

These services are provided for individuals with Medicaid who are living in the community and need help in negotiating different systems in order to better take control of their lives. The primary goal of these services is to help individuals successfully remain in the community while improving the overall quality of their lives. Care Coordination will help clients maintain their mental health and medical treatment with the goal of reducing hospitalizations and emergency services. Care managers will assist clients by coordinating services with mental health and medical providers, and linking clients to community resources to enhance the quality of their lives. For those individuals who do not have Medicaid or are not eligible for Medicaid, care management is provided for clients who are 18 years old, a resident of Suffolk County and who have a primary diagnosis of a major mental illness as described in the DSM V. The primary diagnosis cannot be drug/alcohol, mental retardation, organic disorder or developmental disability. The target population is the serious and persistently mentally ill client (SPMI) whose diagnosable mental illness significantly impairs his/her ability to function in the community without supports.

ASSERTIVE COMMUNITY TREATMENT TEAM (ACT):

These services are intended for those clients most at risk. Priority is given to individuals with continuous high service needs that are not being met in more traditional service settings. This would include clients with serious functional impairments which prevent them from consistently performing practical daily living tasks required for basic adult functioning in the community without significant support, inability to sustain employment and inability to maintain a safe living situation. These clients are generally high users of services including frequent acute psychiatric hospitalizations, emergency and/or crisis services and criminal justice involvement. Intensive community-based, skills training, support and treatment services are provided by an interdisciplinary team of mental health professionals. ACT Teams provide a minimum of six face-to-face visits per month, one of which may be with a collateral. ACT Team services are available only for clients who have a primary diagnosis of a major mental illness which cannot be drug/alcohol, mental retardation, organic disorder or developmental disability. The target population is the serious and persistently mentally ill client (SPMI) whose diagnosable mental illness significantly impairs his/her ability to function in the community without supports.

ASSISTED OUTPATIENT TREATMENT (AOT):

AOT, aka "Kendra's Law", provides for court-ordered assisted outpatient treatment for certain people with mental illness who, in view of their treatment history and present circumstances, are unlikely to survive safely in the community without supervision. A person may be ordered to obtain Assisted Outpatient Treatment (AOT) if the court finds that he or she: is at least 18 years of age and suffers from a mental illness; and is unlikely to survive in the community without supervision, based on a clinical determination; and has a history of non-compliance with treatment for mental illness which has led to either 2 hospitalizations for mental illness in the preceding 3 years, or resulted in at least 1 act of violence toward self or others or threats of serious physical harm to self or others, within the preceding 4 years; and is unlikely to accept the treatment recommended in the treatment plan; and is in need of AOT to avoid a relapse or deterioration that would likely result in serious harm to self or others; and will likely benefit from AOT.

Care Coordination and ACT referrals MUST include:

☐ Adult SPOA Application

☐ Psychiatric Evaluation and Psychosocial Assessment (Must be within one year from submission date) *

☐ Enclosed HIPAA Release of Information (Must be signed with Witness signature) *

*__Release and Psychiatric Evaluation are NOT required for AOT referral__

Adult SPOA application available on this website:

http://www.suffolkcountyny.gov/departments/healthservices/mentalhygiene

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SPOA Application for Adult Services

Suffolk County Adult Single Point of Access Unit

Application Date: ______________________

Services Requested: ☐ **AOT (Kendra's Law)**

☐ **Care Coordination** ☐ **ACT Team**

Individual Referred

Last Name: ______________ First Name: ______________ MI: ______

DOB: ______________ Sex: ________ SS#: ______________

Telephone: Home ______________ Alternate ______________

Address: ______________________________

City: ______________ State: ______________ Zip: ______________

Type of Housing: ☐ Community Residence ☐ Supported Housing/Apt. Treatment ☐ Adult Home ☐ Private Home/Apartment ☐ Room and Board ☐ DSS Emergency Housing ☐ Sober House ☐ Other:

Has Individual Referred submitted a SPA Application? ☐ Yes ☐ No

If yes, please list status of application: ______________________________

If individual is not **physically located** at address above, please list **current location** below

Address: ______________________________

City: ______________ State: ______________ Zip: ______________

Telephone: ______________ Fax: ______________

If Individual has **children**, list names, dates of birth, and indicate whether living with Individual

Name	Date of Birth/ Age	Living with Individual?
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

Individual Name: ______________________

Contacts

Emergency Contact Name: ______________________

Address: ______________________

City: ____________ State: ____________ Zip: ____________

Telephone: ____________ Relation: ____________

☐ **Next of Kin** *(Next of Kin required for AOT referrals)*

Name: ____________ Phone #: ____________

Address: ______________________

City: ____________ State: ____________ Zip: ____________

☐ **Guardian** ☐ **Heath Care Proxy** ☐ **Power of Attorney** (list any that apply) ☐ None

Name: ____________ Phone #: ____________

Address: ______________________

City: ____________ State: ____________ Zip: ____________

Medical Coverage ☐ None ☐ Pending

☐ Medicaid Medicaid #: ______________________

☐ Medicare Medicare #: ____________ ☐ Part A ☐ Part B

☐ Other insurance company: ______________________

☐ Managed Care Organization (MCO): ______________________

☐ Level of Care Determination: ______________________

☐ Inactive ☐ Approved ☐ Denied

Benefits ☐ None

☐ Active ☐ Inactive ☐ Pending

☐ PA $: ________ ☐ SSI $: ________ ☐ SSD $: ________ ☐ VA $: ________

☐ Other Benefit $: $ Type: ____________ $ Amt: ____________

☐ Rep-payee Name: ____________ Telephone: ____________

Individual Name: ____________________________

Individual's Diagnosis per DSM-5* *Diagnostic and Statistical Manual of Mental Health Disorders, American Psychiatric Association

list all diagnoses, including SMI (severe mental illness), personality disorders, and/or developmental disorders

Mental Health Diagnosis: ____________________________

ICD 10 Code: ____________________________

Substance Use Diagnosis: ____________________________

ICD 10 Code: ____________________________

Individual's Physical Health Diagnosis

☐ None

☐ Advanced Coronary Artery Disease ☐ Cerebrovascular Disease ☐ Congestive Heart Failure

☐ Heart Disease ☐ Hypertension ☐ Peripheral Vascular Disease ☐ BMI over 25

☐ Chronic Renal Failure ☐ Diabetes ☐ Asthma ☐ Chronic Obstructive Pulmonary Disease

☐ Other: ____________________________

Behavioral Health Services – *Please list all current or most recent behavioral health services.*

☐ **Care Coordination** ☐ Open Date: ☐ Closed Date: ☐ None

Agency: ____________ Contact Person: ____________

Email Address: ____________ Telephone: ____________

Address: ____________ Fax: ____________

City: ____________ State: ____________ Zip: ____________

☐ **Outpatient Mental Health Treatment** ☐ Open Date: ☐ Closed Date: ☐ None

Agency: ____________ Contact Person: ____________

Email Address: ____________ Telephone: ____________

Address: ____________ Fax: ____________

City: ____________ State: ____________ Zip: ____________

☐ **Substance Use Disorder Treatment** ☐ Open Date: ☐ Closed Date: ☐ None

Agency: ____________ Contact Person: ____________

Email Address: ____________ Telephone: ____________

Address: ____________ Fax: ____________

City: ____________ State: ____________ Zip: ____________

Individual Name: ____________________

Psychotropic Medication

Name of Medication Prescribed	Dosage	Name of Prescriber

Explanation of Need for Services – *Briefly explain the Individual's need for Care Coordination, ACT, or AOT services.*

Compliance

Is individual compliant with treatment? ☐ Yes ☐ No Is individual compliant with medication? ☐ Yes ☐ No

If No to either of the above (and applying for AOT), *Describe what occurs when the individual is non-compliant and list any precipitating factors of the non-compliance.*

Individual Name: ______________________________

Hospitalizations (within the last four years) *Begin with the most recent hospitalization.*		
Name of Facility	Admission and Discharge Dates	Reason for Admission

Acts of Violence – *List any acts of violence or threats of serious physical harm towards self or others within the past 48 months.*		
Date of threat or act of violence	Name and relationship of person to whom threat or act of violence was made	Description of threat or act of violence (indicate any police/Mobile Crisis Team involvement)

Criminal Justice System Involvement

☐ None

Type	Dates	Contact Person and Telephone
Parole/Probation		
Correctional Facility/Prison		
Specialty Court *(Circle if Applies)* Mental Health / Drug / Domestic Violence Court		
Sex Offender Registrant		
Order of Protection (OOP)*		

**Please list name of person who holds OOP and the relationship to individual:*

Involvement within Other Systems

☐ None

Type	Dates	Contact Person and Telephone
AOT Program (Current or Past Order or Diversion)		
Child Protective Services (CPS)		
CPL Order		

Physical Description of Individual

Name: ____________________

Known alias: ____________________

Date of birth: ____________________

Race/Ethnicity: ____________________

Is individual fluent in/understand English? __________ Primary Language: __________

Height: __________ Weight: __________

Hair: __________ Eye Color: __________

Other distinguishing, if applicable (Tattoos, scars, glasses, etc.): ____________________

Referral Source

Person Making Referral: ______________________________

Relationship to Individual: ______________________________

Email Address: ______________________ Telephone: ______________

Address: ______________________ Fax: ______________

City: ______________ State: ______________ Zip: ______________

IF APPLYING FOR AOT, THE REFERRAL SOURCE MUST READ AND SIGN THE STATEMENT BELOW.

Once the Assisted Outpatient Treatment (AOT) unit receives a completed application, an AOT investigation will be opened for the individual. This process can be a lengthy one. Should the individual need immediate or emergent psychiatric intervention, you should contact the police (via 911) or the Suffolk County Mobile Crisis Team (MCT) at (631) 952-3333. If the individual currently has a treating provider (such as a private psychiatrist/therapist or a mental health agency), this provider remains responsible for the individual's psychiatric care during the AOT investigation. **Please take notice:** Due to the NYS Court of Appeals decision of May 10, 2011 the AOT program is required to seek authorization from the patient for the release of his/her medical records or other Protected Health Information (PHI) under the Health Insurance Portability and Accountability ACT (HIPAA). If the patient does not consent to the release of their records, the Suffolk County Division of Mental Hygiene may seek to obtain those records via a court order. If that becomes necessary, the referral source will be named, and the referring party may be disclosed to the patient.

*****PLEASE SIGN THAT YOU HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS:**

Signature of Referring Party: ______________________ Date: ______________

Name of Referring Party: ______________________

If you have any questions or concerns that you would like to discuss further, please contact the Adult SPOA Unit Monday through Friday from 9 AM to 5 PM.

Jenine Yannucciello, LCSW
Director of Adult Services

Mail or Fax to:

Adult SPOA Unit
Suffolk County Division of Community Mental Hygiene
William J. Lindsay County Complex, Building C016
P.O. Box 6100
Hauppauge, New York 11788
Adult SPOA Phone Number: (631) 853-6204
AOT Phone Number: (631) 853-6205
Adult SPOA & AOT Fax Number: (631) 853-6451

Authorization for Release of Health Information (Including Alcohol/Drug Treatment and Mental Health Information) and Confidential HIV/AIDS-related Information

Patient Name	Date of Birth	Patient Identification Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG TREATMENT, MENTAL HEALTH TREATMENT, and CONFIDENTIAL HIV/AIDS-RELATED INFORMATION only if I place my initials on the appropriate line in item 8. In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 8, I specifically authorize release of such information to the person(s) indicated in Item 6.
2. With some exceptions, health information once disclosed may be re-disclosed by the recipient. If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the provider listed below in Item 5. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

5. Name and Address of Provider or Entity to Release this Information:
Adult SPOA, Suffolk County Division of Community Mental Hygiene, PO Box 6100, Hauppauge, NY 11788

6. Name and Address of Person(s) to Whom this Information Will Be Disclosed: **Association for Mental Health & Wellness/ New York State Care Coordination/ Hudson River Health Care/ EAC Network/ Family Service League/ Federation of Organizations/ Stony Brook University Sayville Project/ Well Life Network**

7. Purpose for Release of Information: Referral for Care Coordination and/or ACT Services

8. Unless previously revoked by me, the specific information below may be disclosed from: ______________ (INSERT START DATE) until **1 year from start date** (INSERT EXPIRATION DATE OR EVENT)

☐ All health information (written and oral), except:

____

For the following to be included, indicate the specific information to be disclosed and initial below.	Information to be Disclosed	Initials
☒ Records from alcohol/drug treatment programs	**Psychosocial/Psychiatric Evaluations**	
☒ Clinical records from mental health programs*	**Psychosocial/Psychiatric Evaluations**	
☐ HIV/AIDS-related Information		

9. If not the patient , name of person signing form:	10. Authority to sign on behalf of patient:

All items on this form have been completed, my questions about this form have been answered and I have been provided a copy of the form.

☐ Patient declined copy

SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED BY LAW ______________ DATE ______________

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 authorized representative.

STAFF PERSON'S NAME AND TITLE ______________ SIGNATURE ______________ DATE ______________

This form may be used in place of DOH2557 and/or OMH 11 or 11A and has been approved by the NYS Office of Mental Health and NYS Office of Alcoholism and Substance Abuse Services to permit release of health information or mental health clinical records. However, this form does not require health care providers to release health information. Alcohol/drug treatment related information or confidential HIV-related information released through this form must be accompanied by the required statements regarding prohibition of redisclosure.

*Note: Information from mental health clinical records may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person.

SUFFOLK COUNTY ADULT SPOA- CONTRACT CARE COORDINATION/ ACT/ HEALTH HOME AGENCIES

ASSOCIATION FOR MENTAL HEALTH AND WELLNESS – (MHAW)
ADMINISTRATIVE OFFICE
939 JOHNSON AVENUE
RONKONKOMA, NY 11779

NEW YORK STATE CARE COORDINATION – (SUFFOLK COUNTY ICM)
ADMINISTRATIVE OFFICE
998 Crooked Hill Road, Bldg. 69
Brentwood, NY 11717

HUDSON RIVER HEALTH CARE – (CCC HRH CARE)
ADMINISTRATIVE OFFICE
1200 BROWN STREET
PEEKSKILL, NY 10566

EAC NETWORK –
ADMINISTRATIVE OFFICE
50 CLINTON STREET, SUITE 107
HEMPSTEAD, NY 11550

FAMILY SERVICE LEAGUE- (FSL)
ADMINISTRATIVE OFFICE
790 PARK AVENUE
HUNTINGTON, NY 11743

FEDERATION OF ORGANIZATIONS –
ADMINISTRATIVE OFFICE
1 FARMINGDALE ROAD
WEST BABYLON, NY 11704

STONY BROOK UNIVERSITY/SAYVILLE PROJECT –
ADMIINSTRATIVE OFFICE
640 JOHNSON AVENUE, SUITE 2
BOHEMIA, NY 11716

WELL LIFE NETWORK – ADMINISTRATIVE OFFICE
120 COMMERCE DRIVE, SUITE 102
HAUPPAUGE, NY 11788