



STEVEN BELLONE
SUFFOLK COUNTY EXECUTIVE

DEPARTMENT OF HEALTH SERVICES

GREGSON H. PIGOTT, MD, MPH
COMMISSIONER

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. The target population is an individual diagnosed with a Severe Mental Illness (SMI) that significantly impairs his/her ability to function in the community without supports. The primary diagnosis cannot be a Substance Use Disorder, an organic disorder, or a developmental disability.

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 diagnosed with a Severe Mental Illness (SMI) that significantly impairs his/her ability to function in the community without supports. The primary diagnosis cannot be a Substance Use Disorder, an organic disorder, or a developmental disability.

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 noncompliance 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; is unlikely to accept the recommended treatment plan voluntarily; 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>

SPOA Application for Adult Services

Suffolk County Adult Single Point of Access Unit



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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?
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> 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 **Health 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: _____

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)

Individual Name: _____

Criminal Justice System Involvement None

Type	Dates	Contact Person and Telephone
Parole/Probation		
Correctional Facility/Prison		
Specialty Court (<i>Circle if Applies</i>) 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/Northwell Health

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: _____ until 1 year from start date <small style="margin-left: 100px;">INSERT START DATE</small> <small style="margin-left: 100px;">INSERT EXPIRATION DATE OR EVENT</small>
<input type="checkbox"/> 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
<input checked="" type="checkbox"/> Records from alcohol/drug treatment programs	Psychosocial/Psychiatric Evaluations	
<input checked="" type="checkbox"/> Clinical records from mental health programs*	Psychosocial/Psychiatric Evaluations	
<input type="checkbox"/> HIV/AIDS-related Information		

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

ADMINISTRATIVE OFFICE

640 JOHNSON AVENUE, SUITE 2
BOHEMIA, NY 11716

WELL LIFE NETWORK – ADMINISTRATIVE OFFICE

120 COMMERCE DRIVE, SUITE 102 HAUPPAUGE,
NY 11788

NORTHWELL HEALTH - ADMINISTRATIVE OFFICE

600 COMMUNITY DRIVE, SUITE 400
MANHASSET, NY 11030



SCDOH CMH Adult SPOA Unit is:

Suffolk County Department of Health Community Mental Hygiene Adult Single Point of Access Unit

Provider/Facility Name

About PSYCKES

The New York State (NYS) Office of Mental Health maintains the Psychiatric Services and Clinical Enhancement System (PSYCKES). This online database stores some of your medical history and other information about your health. It can help your health providers deliver the right care when you need it.

The information in PSYCKES comes from your medical records, the NYS Medicaid database and other sources. Go to www.psyckes.org, and click on **About PSYCKES**, to learn more about the program and where your data comes from.

This data includes:

- Your name, date of birth, address and other information that identifies you;
- Your health services paid for by Medicaid;
- Your health care history, such as illnesses or injuries treated, test results and medicines;
- Other information you or your health providers enter into the system, such as a health Safety Plan.

What You Need to Do

Your information is confidential, meaning others need permission to see it. Complete this form now or at any time if you want to give or deny your providers access to your records. What you choose will not affect your right to medical care or health insurance coverage.

Please read the back of this page carefully before checking one of the boxes below. Choose:

- “I GIVE CONSENT” if you want this provider, and their staff involved in your care, to see your PSYCKES information.
- “I DON’T GIVE CONSENT” if you don’t want them to see it.

If you don’t give consent, there are some times when this provider may be able to see your health information in PSYCKES – or get it from another provider – when state and federal laws and regulations allow it.¹ For example, if Medicaid is concerned about the quality of your health care, your provider may get access to PSYCKES to help them determine if you are getting the right care at the right time.

Your Choice. Please check 1 box only.

I GIVE CONSENT for the provider, and their staff involved in my care, to access my health information in connection with my health care services.

I DON’T GIVE CONSENT for this provider to access my health information, but I understand they may be able to see it when state and federal laws and regulations allow it.

Print Name of Patient

Patient’s Date of Birth

Patient’s Medicaid ID Number

Signature of Patient or Patient’s Legal Representative

Date

Print Name of Legal Representative (if applicable)

Relationship of Legal Representative Patient (if applicable)

¹ Laws and regulations include NY Mental Hygiene Law Section 33.13, NY Public Health Law Article 27-F, and federal confidentiality rules, including 42 CFR Part 2 and 45 CFR Parts 160 and 164 (also referred to as “HIPAA”).

- 1 **How providers can use your health information.** They can use it only to:
 - Provide medical treatment, care coordination, and related services.
 - Evaluate and improve the quality of medical care.
 - Notify your treatment providers in an emergency (e.g., you go to an emergency room).
- 2 **What information they can access.** If you give consent, **SCDOH CMH Adult SPOA Unit** can see ALL your health information in PSYCKES. This can include information from your health records, such as illnesses or injuries (for example, diabetes or a broken bone), test results (X-rays, blood tests, or screenings), assessment results, and medications. It may include care plans, safety plans, and psychiatric advanced directives you and your treatment provider develop. This information also may relate to sensitive health conditions, including but not limited to:

<ul style="list-style-type: none"> • Mental health conditions • Alcohol or drug use • Birth control and abortion (family planning) 	<ul style="list-style-type: none"> • Genetic (inherited) diseases or tests • HIV/AIDS • Sexually transmitted diseases
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- 3 **Where the information comes from.** Any of your health services paid for by Medicaid will be part of your record. So are services you received from a state-operated psychiatric center. Some, but not all information from your medical records is stored in PSYCKES, as is data you and your doctor enter. Your online record includes your health information from other NYS databases, and new databases may be added. For the current list of data sources and more information about PSYCKES, go to: www.psyckes.org and see “About PSYCKES”, or ask your provider to print the list for you.
- 4 **Who can access your information, with your consent.** **SCDOH CMH Adult SPOA Unit**’s doctors and other staff involved in your care, as well as health care providers who are covering or on call for **SCDOH CMH Adult SPOA Unit**. Staff members who perform the duties listed in #1 above also can access your information.
- 5 **Improper access or use of your information.** There are penalties for improper access to or use of your PSYCKES health information. If you ever suspect that someone has seen or accessed your information – and they shouldn’t have – call:
 - _____ at _____, or
 - the NYS Office of Mental Health Customer Relations at **800-597-8481**.
- 6 **Sharing of your information.** **SCDOH CMH Adult SPOA Unit** may share your health information with others only when state or federal law and regulations allow it. This is true for health information in electronic or paper form. Some state and federal laws also provide special protections and additional requirements for disclosing sensitive health information, such as HIV/AIDS, and drug and alcohol treatment.¹
- 7 **Effective period.** This Consent Form is in effect for 3 years after the last date you received services from _____, or until the day you withdraw your consent, whichever comes first.
- 8 **Withdrawing your consent.** You can withdraw your consent at any time by signing and submitting a Withdrawal of Consent Form to **SCDOH CMH Adult SPOA Unit**. You also can change your consent choices by signing a new Consent Form at any time. You can get these forms at www.psyckes.org or from your provider by calling **SCDOH CMH Adult SPOA Unit** at **631 853-6204**. Please note, providers who get your health information through **New York State OMH PSYKES** while this Consent Form is in effect may copy or include your information in their medical records. If you withdraw your consent, they don’t have to return the information or remove it from their records.
- 9 **Copy of form.** You can receive a copy of this Consent Form after you sign it.

¹ Laws and regulations include NY Mental Hygiene Law Section 33.13, NY Public Health Law Article 27-F, and federal confidentiality rules, including 42 CFR Part 2 and 45 CFR Parts 160 and 164 (also referred to as “HIPAA”).