COUNTY of NASSAU
DEPARTMENT OF HUMAN SERVICES
Office of Mental Health, Chemical Dependency and Developmental Disabilities Services
60 Charles Lindbergh Boulevard, Suite 200, Uniondale, New York 11553-3687
Phone: (516) 227-7057 Fax: (516) 227-7076

ALL APPLICATIONS ON BEHALF OF INDIVIDUALS WITH A SERIOUS MENTAL ILLNESS AND/OR A SUBSTANCE USE DISORDER MUST BE SUBMITTED TO THE NASSAU COUNTY SPOA AT THE ABOVE ADDRESS

ALL MENTAL HEALTH AND SUBSTANCE USE DISORDER PROGRAMS MUST INCLUDE PSYCHOSOCIAL AND PSYCHIATRIC EVALUATIONS

NASSAU COUNTY CARE COORDINATION COMMUNITY REFERRAL

(To be used for any referral within Nassau County for medical, behavioral health and substance abuse care management services)

Services Referred to *(check all that apply)* ☐ **Care Coordination** ☐ **ACT** ☐ **AOT**

Date:

Last Name	**First Name**	**SSN**

Address:
Street Apt.
Town State Zip

Alt. Address:
Street Apt.
Town State Zip

AKA (also known as):

Home Phone:	Mobile Phone:	Alt. Phone:

E-mail address:

DEMOGRAPHIC INFORMATION

DOB: Age: Gender: ☐ Male ☐ Female ☐ Transgender

Race: ☐ White ☐ Hispanic/Latino ☐ Alaskan Native ☐ Native Hawaiian
☐ Black ☐ Asian ☐ American Indian ☐ Pacific Islander
☐ Other, specify:

Ethnicity: ☐ Hispanic ☐ Not Hispanic

Primary Language (spoken at home): ☐ English ☐ Spanish ☐ Other (specify):

Primary Language During Service Provision: ☐ English ☐ Spanish ☐ Other (specify):

If necessary, who will interpret?

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ENTITLEMENTS	
☐ Medicaid	Medicaid Number:
☐ Medicaid Managed Care	Medicaid Number: Managed Care Provider:
☐ Medicare	Medicare number:
☐ Private Insurance	Insurance Provider:
☐ No Insurance	

REFERRAL SOURCE

☐ Self, family or friend	☐ MR/DD Facility	☐ Family Court	☐ Managed Care Organization
☐ Mental Health outpatient	☐ General Hospital ER	☐ Criminal Court	☐ Care Management Agency
☐ Mental Health inpatient	☐ General Hospital (inpatient)	☐ Parole	☐ Other Health Home: specify:
☐ Mental Health residential	☐ Other medical provider	☐ Probation	
☐ Substance Abuse Program		☐ Jail, penitentiary, etc.	

Applicant:	Medicaid #

REFERRAL INFORMATION		
Name		
Title:		
Agency:		
Phone #:		Ext:

Signature of Referring Person _____

Applicant diagnosis per DSM-V* List all diagnoses, including SMI(severe mental illness) personality Disorders, and/or developmental disabilities		
Mental Health Diagnosis		
Substance Use Disorder Diagnosis		
Other: Specify		
	Current:	**Past Year:**

FOR ALL REFERALLS PLEASE CHECK ALL APPLICABLE BOXES

IF SUBSTANCE USE DISORDER IS THE PRIMARY DIAGNOSIS ONE OF THE BOXES BELOW MUST BE CHECKED

MEDICAL DIAGNOSIS (check all that apply)	
☐ Asthma	☐ Hypertension
☐ Diabetes	☐ Obesity (BMI >25)
☐ Advanced Coronary Artery Disease	☐ HIV/AIDS
☐ Heart Disease	☐ Chronic Obstructive Pulmonary Disease
☐ Congestive Heart Failure	☐ Cerebrovascular Disease
☐ Chronic Renal Failure	☐ Other, Specify

Number of Psychiatric Hospitalizations:	
Number of Psychiatric Hospitalizations within Past Year:	

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ATTACH AVAILABLE SUPPORTING DOCUMENTATION OF MEDICAL DIAGNOSIS

MENTAL HEALTH/SUBSTANCE USE/MEDICAL PROVIDERS, *if known*	
Outpatient MH Treatment Provider	Name
	Phone
Outpatient Substance Abuse Provider	Name
	Phone
Primary Health Care Provider	Name
	Phone
Other Medical Provider	Name
Specialty:	Phone
Other Medical Provider	Name
Specialty:	Phone

APPROPRIATENESS FOR HEALTH HOME *(Significant behavioral, medical or social risk factors that can be addressed through care coordination)* **CHECK ALL THAT APPLY AND EXPLAIN BELOW**

- ☐ Probable risk for adverse event, e.g., death, disability, inpatient or nursing home admission
- ☐ Lack of or inadequate social/family/housing support
- ☐ Lack of or inadequate connectivity with healthcare system
- ☐ Non-adherence to treatments or medication(s) or difficulty managing medications
- ☐ Recent release from incarceration or psychiatric hospitalization
- ☐ Deficits in activities of daily living such as dressing, eating, etc.
- ☐ Learning or cognitive issues

Applicant:	Medicaid #

Rationale (provide explanation/information/examples of items checked above, e.g., client is a BOCES graduate with cognitive impairments and diabetes who has lost his support network and is having difficulty keeping appointments):

TO BE COMPLETED ONLY FOR ASSISTED OUTPATIENT TREATMENT (AOT)

Applicant Name: _____

Referral Source:	
Relationship to Referred Party:	
Address:	
Telephone No.	**Fax No.**
Application Date:	

Is client currently hospitalized? If so, where _____

Is this individual currently prescribed any **psychotropic medications**? Yes ☐ No ☐
If Yes, the following section **MUST** be completed:

Name of Prescriber: _____

Name of Medication Prescribed	Dosage	Is the individual currently taking this medication?
		Yes ☐ No ☐
		Yes ☐ No ☐
		Yes ☐ No ☐
		Yes ☐ No ☐
		Yes ☐ No ☐

Does this individual currently receive **outpatient alcohol or substance use disorder** services? Yes ☐ No ☐

If **Yes**, the following section **MUST** be completed:

Outpatient Treatment Agency:			Therapist:
Address:			
City:	State:	ZIP:	Telephone No.:

Does this individual have an alcohol or substance abuse diagnosis that is documented? Yes ☐ No ☐

Does this individual require psychotropic medications to maintain stability? Yes ☐ No ☐

Does this individual have a history of non-compliance with psychotropic medications? Yes ☐ No ☐

List all **prior treatments**, including psychotropic medications that this individual has been non-compliant with:

Treatment Modality	Date/Timeframe of non-compliance	Reason for non-compliance (if known)

Describe what occurs when this person is not compliant and any precipitating factors of the noncompliance:

Has this individual required two or more inpatient admissions to a **psychiatric facility** or **forensic unit** within the past 36 months ***due to non-compliance with medication***? **YES** ☐ **NO** ☐ (NOTE: Exclude all inpatient admission time periods from calculation of 36 months.)

Provide a listing of all Psychiatric Hospitalizations listed below, including admission & discharge dates:

Name of Facility	City, State	Admission and Discharge Dates	Reason for Admission

Has this individual made one or more ***documented*** acts of, or threats of, serious violence towards self or others within the past 48 months ***due to non-compliance with medication***? **YES** ☐ **NO** ☐ (NOTE: Exclude all inpatient admission time periods from calculation of 48 months.)

Provide a listing of **ALL** acts of violence referred to above**:**

Date of threat or act of violence	Name & relationship of person to which threat or act of violence was made	Description of threat or act of violence (indicate if there was police/MCT involvement)

Has this individual been involved with the **criminal justice system**? YES ☐ NO ☐ If yes, describe below:

Criminal Justice/Legal System Involvement:

Is this individual ***currently*** involved with the **criminal justice system**? YES ☐ NO ☐ UNKNOWN ☐

If yes, check the appropriate boxes and provide specifics:

	System	Individual to whom reports are made	Telephone No.
☐	Probation		
☐	Parole		
☐	Order of Protection		
☐	CPL Order		
☐	Correctional Facility		
☐	Court Ordered Treatment		

Have efforts been made to mediate and/or use other methods other than AOT? YES ☐ NO ☐

Please provide specifics:

Date of Intervention	Specific Alternative Suggested	Outcome

Physical Description of client: (**PLEASE PRINT)**

NAME:	
KNOWN ALIASES:	
DATE OF BIRTH:	**RACE/ETHNICITY:**
HEIGHT: _____ft. _____ in.	**WEIGHT: _____**
COLOR OF HAIR:	**COLOR OF EYES:**
OTHER DISTINGUISHING FEATURES (i.e., tattoos, glasses, skin tone, missing teeth, gait)	

Notice to Referral Source:

Once the AOT Coordination Team receives a completed application, and the CRT Team reviews the application for eligibility, an AOT investigation will be opened to determine if he/she meets the criteria for AOT set by Kendra's Law. This process can be a lengthy one, often several weeks long. The AOT program, in itself, is not psychiatric treatment, nor is it crisis intervention. Should the individual need immediate or emergency psychiatric intervention, you should contact the police (via 911) or the Mobile Crisis Team (516-227-8255), who can evaluate the individual to determine the need for psychiatric hospitalization or provide a referral to an appropriate treatment agency.

In addition, if the individual currently has a treating provider, such as a private psychiatrist/ therapist or is a patient at a mental health agency, this provider remains responsible for the individual. The AOT application and investigation process does not relieve the provider of their responsibility to continue to treat the patient. This provider should contact the AOT Coordination Team, to assist in providing relevant information and developing an appropriate treatment plan for the individual. An AOT treatment plan may or may not include continuation of care by the Current provider.

If you have any questions or concerns that you would like to discuss further, please contact the AOT Coordination Team Monday through Friday at (516) 227-7057.