

COUNTY OF SUFFOLK



STEVE BELLONE
SUFFOLK COUNTY EXECUTIVE

DEPARTMENT OF HEALTH SERVICES

JAMES L. TOMARKEN, MD, MPH, MBA, MSW
Commissioner

Notice to Referral Source:

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 : _____

If you have any questions or concerns that you would like to discuss further, I can be reached Monday through Friday at (631) 853-6205.

Sincerely,

J L Yannucciello, LCSW

*Jenine Yannucciello, LCSW
Suffolk County AOT Program Coordinator*



Public Health
Prevent. Promote. Protect.

ASSISTED OUTPATIENT TREATMENT (AOT)
PO BOX 6100, HAUPPAUGE, NEW YORK 11788
TEL: (631) 853-6205 FAX: (631) 853-8522

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DIVISION OF COMMUNITY MENTAL HYGIENE SERVICES
ARTHUR FLESCHER, LCSW, CASAC
DIRECTOR

Application for

Court-Ordered Assisted Outpatient Treatment

Referral Source _____
Relationship to Referred Party _____
Address (line1) _____
Address (line2) _____
Tel # _____ Fax # _____
Application Date: _____ (2011 Version 3)

• Person referred for AOT:

LAST:	FIRST:	M.I.	SEX:	D.O.B:
ADDRESS:				
CITY:	STATE:	ZIP:	TELEPHONE:	
MEDICAID#:	C# (If Known):	SS#:		

• Is this individual currently at this address? Yes No. If not, where is he/she physically located?

ADDRESS 1:				
ADDRESS 2:				
CITY:	STATE:	ZIP:	TELEPHONE:	
TELEPHONE:		FAX:		

• Does this individual currently receive case management services? Yes No.

If Yes, the following section MUST be completed. **If No, complete attached MINI-CAMERA Application.*

CASE MANAGEMENT AGENCY:	CASE MANAGER:
ADDRESS:	
CITY:	STATE: ZIP:
TELEPHONE:	FAX:

• Does this individual currently receive outpatient mental health services? Yes No.

If Yes, the following section MUST be completed:

OUTPATIENT TREATMENT AGENCY:	THERAPIST:
ADDRESS:	
CITY:	STATE: ZIP:
TELEPHONE:	FAX:

• 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?

Last _____ First _____ MI _____

- Does this individual currently receive **outpatient alcohol or substance abuse** services? Yes No.
If Yes, the following section MUST be completed:

OUTPATIENT TREATMENT AGENCY:	THERAPIST:
ADDRESS:	
CITY:	STATE: ZIP:
TELEPHONE:	FAX:

- Is this individual over the age of eighteen? Yes No. Age: _____
- Does this individual have a **diagnosed mental illness** that is documented? Yes No.
- Does this individual have an **alcohol or substance abuse diagnosis** that is documented? Yes No.

DSM-IV AXIS	DIAGNOSTIC CODE	DESCRIPTION of DIAGNOSIS
I PRIMARY		
I		
II		
II		
III		
IV		
V		

Date of Diagnosis: _____ Diagnosed By: _____ Title: _____

- 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)

Last _____ First _____ MI _____

- Has this individual made one or more acts of, or threats of, serious violence towards self or others within the past 48 months? 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.
Check the appropriate boxes and provide specifics:

	System	Individual to whom reports are made	Telephone #
<input type="checkbox"/>	Probation		
<input type="checkbox"/>	Parole		
<input type="checkbox"/>	Order of Protection		
<input type="checkbox"/>	CPL Order		
<input type="checkbox"/>	Correctional Facility		
<input type="checkbox"/>	Court-Ordered Treatment		

Last _____ First _____ MI _____

- Based upon your knowledge of the client, to what extent is this person unable to survive in the community without the assistance of AOT? Check all categories and complete comment section below:

Area of Functioning	Severity of Impairment Rating				
	Severe	Moderate	Mild	No Problem	Unknown
Self-directed aggression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aggression towards others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-neglect / endangerment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol/ Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Housing / Homelessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Financial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Activity of Daily Living Skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Legal Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: Specify	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments: _____

- 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

Last _____ First _____ MI _____

Assisted Outpatient Treatment Program

Physical Description of Individual being referred for AOT:

NAME: _____

Known alias's: _____

Date of Birth: _____

Race/Ethnicity: _____

Height: _____

Weight: _____

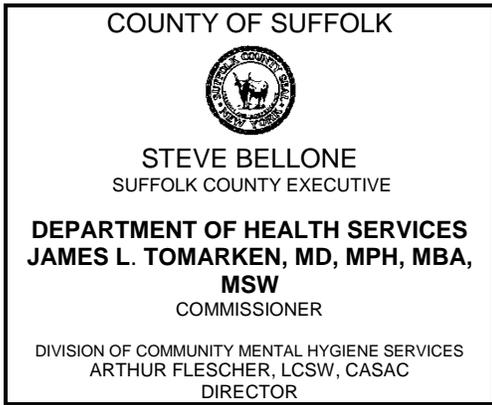
Hair: _____

Eyes: _____

Other distinguishing: _____

If applicable (i.e.; Tattoos, glasses, skin tone, teeth w/without, walking gait)

<p><i>FORWARD COMPLETED APPLICATION TO:</i></p> <p>ASSISTED OUTPATIENT TREATMENT PROGRAM SUFFOLK COUNTY DIVISION OF COMMUNITY MENTALHYGIENE SERVICES NORTH COUNTY COMPLEX- BUILDING C928 P.O. BOX 6100, 725 VETERANS MEMORIAL HIGHWAY HAUPPAUGE, NEW YORK 11788</p> <p>PHONE (631) 853-6205 FAX (631) 853-8522</p>



MINI-CAMERA Addendum to Application for Court-Ordered Assisted Outpatient Treatment

Client Name: _____
 Address: _____
 Telephone #: _____
 S.S.#: _____ D.O.B: _____
 Male Female Application Date: _____
 Contact Person: _____

• Applicant's primary Axis I diagnosis code number as per DSM IV: _____
 Diagnosis Description: _____

Additional Codes: Axis I _____ Axis II _____ Axis III _____ Axis IV _____ Axis V _____

• Psychotropic Medications: _____

• Outpatient Treatment Program/Clinic: _____
 Address: _____ Tel #: _____
 Date of next appointment: _____ Time of appointment: _____

• Most recent or current Psychiatric Hospitalization:
 Hospital Name: _____ From: _____ To: _____

• Previous Psychiatric Hospitalizations – NUMBER in each year:
 Before 2006__ 2007__ 2008__ 2009__ 2010__ 2011__ 2012__

• **EXPLANATION OF NEED FOR CASE MANAGEMENT SERVICES: (required)**

• **EMERGENCY CONTACT:** Name _____ Relationship _____
 Address _____ Telephone # _____

• Does applicant have medical coverage? Yes No Pending

Medicaid # _____ Medicare # _____ Part A B

Other insurance company _____

Is applicant enrolled in a Managed Care program? Yes-Program _____ No

Does applicant have a Rep-payee? Yes No

Name _____ Tel # _____

