

COUNTY OF SUFFOLK



STEVE LEVY  
SUFFOLK COUNTY EXECUTIVE

DEPARTMENT OF HEALTH SERVICES  
HUMAYUN J. CHAUDHRY, D.O., M.S.  
COMMISSIONER

DIVISION OF COMMUNITY MENTAL HYGIENE SERVICES  
THOMAS O. MACGILVRAY, CSW, CASAC  
DIRECTOR

## Application For

# Court-Ordered Assisted Outpatient Treatment

Referral Source \_\_\_\_\_

Relationship to Referred Party \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

Tel # \_\_\_\_\_ Fax # \_\_\_\_\_

Application Date: \_\_\_\_\_

• **Person Referred for AOTP:**

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

• **Is this individual currently at this address?** [ ] Yes [ ] No. If not, where is this individual physically located:

ADDRESS:		
ADDRESS:		
CITY:	STATE:	ZIP:
TELEPHONE:		

• **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:	

• **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:	

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:	

- Is this individual over the age of eighteen?  Yes  No. Date of Birth \_\_\_\_\_
- 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	DIAGNOSTIC DATE	DESCRIPTION
I PRIMARY			
I			
II			
II			
III			
IV			
V			

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 treatments, including psychotropic medications, which this individual has a history of non-compliance. Include a description of timeframes and reasons for non-compliance (if known):

Treatment Modality	Date / Timeframe of non-compliance	Reason for non-compliance.



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. Dates of police or Mobile Crisis Team involvement MUST be included.

Incident or Threat Date	Against Whom & Relationship to Person for which this AOTP application is made	Description of Incident or Threat (If Police were involved, so indicate)

- Has this individual had Detox admissions, excluding psychiatric admissions, within the past 36 months? [ ] Yes [ ] No.

Provide a listing of ALL Detox admissions referenced above. Dates of admission and discharge MUST be included.

Facility	City, State	Admission and Discharge Dates	Reason for Admission

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 the AOTP? Check all categories and complete comment section below.

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

Comments:


- Has this individual been involved with the criminal justice system? [ ] Yes [ ] No. If Yes, describe below.

Criminal Justice / Legal System Involvement:


Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_

- 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		

- 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

**PLEASE ATTACH ADDITIONAL PAGES IF NEEDED**

**FORWARD COMPLETED APPLICATION WITH REQUIRED DOCUMENTATION  
AND CURRENT CLINICAL ASSESSMENT TO:**

**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  
PHONE (631) 853-6205 FAX (631) 853-8522**

Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_

**Assisted Outpatient Treatment Program**

Please complete and return to A.O.T. as soon as possible.

Fax your response to (631) 853-8522.

**Physical Description of court ordered client:**

**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)**