Name:_____

Date:_____

Monroe County Office of Mental Health
Assertive Community Treatment (ACT) Referral

ACT services are for individuals who are 18 years and older, with severe mental illness. Severe mental illness entails an illness whose symptoms involve either persistent psychotic symptoms or long standing major mood disturbances. ACT recipients must have a major, non-substance abuse, psychiatric diagnosis as their primary clinical diagnosis and have demonstrated barriers to engaging with traditional, clinic type, mental health services.

Forensic ACT services will serve justice-involved adults with severe mental disorders. In addition to meeting NYS ACT guidelines, all referrals will be required to have a history of involvement with the criminal justice system which is defined as one or more of the following:

- Involved in Mental Health Court
- Involved in or pending involvement in Probation or Parole
- Released from jail or prison within a year of referral
- Under arrest and awaiting court proceedings
- Incarcerated and awaiting release
- Involved in Pre-Trial Diversion Program

Services are specifically for those requiring intensive clinical services or with significant functional impairments directly attributable to their psychiatric illness, as demonstrated by at least <u>three</u> of the following conditions. Please check the items that describe the individual's current risk factors.

A: Current court ordered treatment, such as Assisted Outpatient Treatment (AOT) ☐
or Mental Health Court. ☐

B: Persistent and significant difficulty performing routine activities of daily living, or the ability to perform such tasks only with intensive support from friends or relatives. (Examples of these activities are obtaining medical, legal, and housing services; meeting nutritional needs, and maintaining personal hygiene.) ☐
Please describe:

C: Significant and persistent difficulty maintaining employment or carrying out homemaker roles such as preparing meals, washing clothes, budgeting, and child-care. ☐
Please describe:

Name:_____

D: Significant and persistent problems maintaining a safe living situation. ☐
Please describe:

E: More than two psychiatric admissions within the past year. ☐
Please provide an overall hospitalization history, including dates and locations of most recent hospitalizations:

F: Three or more Psychiatric Emergency Room visits in the past year. ☐
Please describe the circumstances:

G: Persistent *major* psychiatric symptoms, such as psychosis, significant affective disturbance, or intense suicidality. ☐
Please be specific:

H: High risk for, or recent history of, criminal justice involvement as a direct result of the symptoms of their psychiatric diagnosis. ☐
Please be specific:

I: History of violent ideation or gesture ☐
Please describe, including significant and persistent triggers, behaviors, and connection to periods of decompensation:

J: Residing in an inpatient or supervised community residence, but could live in a more independent living situation if intensive services are provided, *or* they will require residential or inpatient placement unless more intensive services can be provided. ☐
Please be specific:

Name:_____

K: Documented and persistent difficulty in effectively using traditional office-based outpatient services. ☐
Please be specific:

1: Name of individual requiring services: _____	**4:** Your name and your relationship to person needing services (for example, parent, friend, or care manager): Name: _____ Relationship: _____
2: Date of Birth: _____ Gender: _____	**5:** Name of Agency, if mental health professional or other service provider: _____ If you are not the primary treatment provider, you have discussed this referral with them and they are in agreement: ☐ yes ☐ no, if no please explain _____
3: Individual's Insurance (if any). *No one will be denied service due to an inability to pay: sliding scale fees are available for individuals without insurance.* _____ MEDICAID#: _____	**6:** Your phone number: _____ Best time to call: _____

7: Current Address (if homeless, indicate where individual might be located—such as a particular drop in shelter or other service provider):
8: Current Phone/Contact Number for Individual:
9: Diagnosis:
10: Current Safety / Violence / Risk Factors. Please include any Risk Assessments if available:
11: Current Community Supports (family, friends, care manager, outpatient providers, etc):
12: Legal Concerns:
13: Active Medical Issues:
14: Medication (if on clozapine, please indicate the frequency of blood draws and when next due):
15: Previous treatment experiences, including dates:

16: Note any immediate care management needs:

Date Referral Received by ACT: _____

If possible, please include documentation such as a clinical summary, alerts, risk assessments, medical information, medication administration records, and any recent discharge summaries.

Monroe County has four ACT teams – three at Strong Behavioral Health and one at Rochester Regional Health. Please check a provider if there is a preference.

☐ **Strong Behavioral Health**
Strong Ties ACT Team
2613 West Henrietta Rd.
Rochester, NY 14623
Telephone: 585-279-4900
Fax: 585-461-9504

☐ **Strong Behavioral Health**
Project ACT Team
2613 West Henrietta Rd.
Rochester, NY 14623
Telephone: 585-279-4900
Fax: 585-461-9504

☐ **Rochester Regional Health**
Unity ACT Team
89 Genesee St.
Rochester, NY 14611
Telephone: 585-368-3459
Fax: 585-368-3585

☐ **Strong Behavioral Health/Forensic ACT**
URMC FACT Team
2613 West Henrietta Rd.
Rochester, NY 14623
Telephone: 585-279-4900
Fax: 585-461-9504

Send referral and signed consent to:

Monroe County SPOA (Single Point of Access)
Mo. Co. Office of Mental Health
1099 Jay Street, Bldg J, 3rd Flr
Rochester, NY 14611
Telephone: 585-753-2874
FAX: 585-753-2885
Email: lbabbitt@monroecounty.gov

Monroe County Office of Mental Health
Permission to Use and Disclose Confidential Information

This form is designed to be used by organizations that collaborate with one another in planning, coordinating, and delivering services to persons diagnosed with mental disabilities. It permits use, disclosure, and re-disclosure of confidential information for the purposes of care coordination, delivery of services, payment for services and health care operations. This form complies with the requirements of §33.13 of the New York State Mental Hygiene Law, federal alcohol and drug record privacy regulations (42 CFR Part 2), and federal law governing privacy of education records (FERPA)(20 USC 1232g). It is not for use for HIV-AIDS related information. Although it includes many of the elements required by 45 CFR 164.508(c), this form is not an "Authorization" under the federal HIPAA rules. An "Authorization" is not required because use and disclosure of protected health information is for purposes of treatment, payment or health care operations. (See 45 CFR 164.506.)

1) I hereby give permission to use and disclose health, mental health, alcohol and drug, and education records as described below.

2) The person whose information may be used or disclosed is:

   Name: _____. Date of Birth: _____

3) The information that may be used or disclosed includes (check all that apply):
   - ☐ Mental Health Records
   - ☐ Alcohol/Drug Records
   - ☐ School or Education Records
   - ☐ Health Records
   - ☐ All of the records listed above

4) This information may be disclosed by:
   - ☐ Any person or organization that possesses the information to be disclosed
   - ☐ The persons or organizations listed in Attachment A
   - ☐ The following persons or organizations that provide services to me:

     _____

     _____

5) This information may be disclosed to:
   - ☐ Any person or organization that needs the information to provide service to the person who is subject of the record, pay for those services, or engage in quality assurance or other health care operations related to that person.
   - ☐ The persons or organizations listed in Attachment A
   - ☐ The following persons or organizations:

     _____

     _____

6) The purposes for which this information may be used and disclosed include:
   - Evaluation of eligibility to participate in a program supported by the Monroe County of Mental Health;
   - Delivery of services, including care coordination and case management;
   - Payment for services; and Health Care Operations such as quality assurance

Monroe County Office of Mental Health
Permission to Use and Disclose Confidential Information (con't)

7) I understand that New York State and federal law prohibits persons that receive mental health, alcohol, or drug abuse, and education records from re-disclosing those records without permission. I also understand that not every organization that may receive a record is required to follow the federal HIPAA rules governing use and disclosure of protected health information. I HERERBY GIVE PERMISSION TO THE PERSONS AND ORGANIZATIONS THAT RECEIVE RECORDS PURSUANT TO THIS AUTHORIZATION TO RE-DISCLOSE THE RECORD AND THE INFORMATION IN THE RECORD TO PERSONS OR ORGANIZATIONS DESCRIBED IN PARAGRAPH 5 FOR THE PURPOSES PERMITTED IN PARAGRAPH 6, BUT FOR NO OTHER PURPOSE.

8) This permission expires (check):

☐ On this date _____

☐ Upon the following event _____

9) This permission is limited as follows:

☐ Permission only applies to records for the following time period: _____ to _____

☐ Other limitations: _____

10) I understand that this permission may be revoked. I have received a Notice of Privacy Practices, and understand that if this permission is revoked, it may not be possible to continue to participate in certain programs. I will be informed of that possibility if I wish to revoke permission. I also understand that records disclosed before this permission is revoked may not be retrieved. Any person or organization that relied on this permission may continue to use or disclose records and protected health information as needed to complete work that began because this permission was given.

I am the person whose records will be used or disclosed. I give permission to use and disclose my records as described in this document.

_____ _____
Signature Date

I am the personal representative of the person whose records will be used or disclosed. My relationship is _____. I give permission to use and disclose records as described in this document.

_____ _____
Signature Date

_____
Print Name

Attachment A

This permission to disclose records applies to the following organizations and people who work at those organizations. These organizations work together to deliver services to residents of Monroe County.

Access-VR
Action for a Better Community
Adult Protective Services
Anthony Jordan Health Center
Baden Street Settlement
Balanced Care
Beacon Health Strategies, LLC (Medicaid Managed Care Organization)
Blue Cross/Blue Shield of Western New York/Health Now (Medicaid Managed Care Organization)
Catholic Family Center
Catholic Charities Community Services
Center for Youth
Child Protective Services
Community Care of Rochester, Inc. DBA Visiting Nurse Signature Care
Community Place of Greater Rochester
Companion Care of Rochester
Compeer Rochester
Conifer Park, Inc.
Coordinated Care Services, Inc.
Correct Care Solutions
Crestwood Children's Center
Daisy Marquis Jones Women's Residence
Delphi Drug & Alcohol Services
DePaul Community Services
Department of Corrections and Community Supervision
Eagle Star Housing
East House Corporation
Eldersource / Lifespan
Endeavor Counseling Services
Epilepsy-Pralid, Inc.
Excellus/Centene/Evolve Health (Medicaid Managed Care Organization)
Fidelis (Medicaid Managed Care Organization)
Finger Lakes Area Counseling and Recovery Agency (FLACRA)
Finger Lakes Developmental Disabilities Services Office (DDSO)
Gavia LifeCare Center
Greater Rochester Health Home Network (GRHHN)
Genesee County Mental Health Clinic
HCR Home Care
Health Homes of Upstate New York (HHUNY)
Helio Health, Inc.
Hickok Center
Hillside Family of Agencies
Hillside Children's Center
Huther-Doyle Memorial Institute, Inc.
Ibero-American Action League
Interim Mental Health
Jewish Family Service of Rochester
John L. Norris ATC
Liberty Resources
Lifetime Care
MC Collaborative
Mental Health Association of Rochester
Molina Healthcare
Monroe Correctional Facility
Monroe County Department of Human Services
Monroe County Jail
Monroe County Office of Mental Health
Monroe Plan for Medical Care, Inc.
MVP (Medicaid Managed Care Organization)
National Alliance on Mental Illness (NAMI)
New York Care Coordination Program, Inc.
NY Connects
Office of Addiction Services and Supports (OASAS)
Office of People with Developmental Disabilities (OPWDD)
OnTrack NY
NYS Office of Mental Health
Pathways Methadone Maintenance Treatment Program
Pathway Houses of Rochester
Prime Care (effective 1/14/18 formally known as Correct Care Solutions)
Puerto Rican Youth Development
Recovery Options Made Easy (ROME)
Reentry Association of Western NY (RAWNY)
Rehabilitation Counseling & Assessment Services, LLC.
Rochester/Monroe Recovery Network
Rochester Regional Health
Rochester Psychiatric Center
Rochester Rehabilitation Center
Spectrum Health and Human Services
Steven Schwarzkopf Community Mental Health Center
The Healing Connection, Inc.
Threshold Center
Trillium Health
United Health Care (Medicaid Managed Care Organization)
University of Rochester/Strong Memorial Hospital
Urban League of Rochester
YWCA Supportive Living Program
Venture For the, Inc.
Veteran's Administration
Veteran's Outreach Center
Villa of Hope
Westfall Associates