

Name: _____

Date: _____

***ASSERTIVE COMMUNITY TREATMENT (ACT) REFERRALS
IMPORTANT UPDATE - PLEASE READ***

Assertive Community Treatment (ACT) is one of the specialty behavioral health services that will be carved into managed care. Mainstream Managed Care Organizations (MMCO) and Health and Recovery Plans (HARPs) operating in Monroe County will assume management of this service in the adult Medicaid Managed Care Program beginning October 1, 2016.

As of 10/1/16, all referrals for ACT services for individuals enrolled in Medicaid will require a level of care determination and prior approval by the appropriate MMCO.

The referral source is responsible for contacting the MMCO to initiate this process using the following steps:

1. DETERMINE THE MANAGED CARE ORGANIZATION

If the individual being referred is covered by Medicaid, determine the MMCO. Please indicate the MMCO and the individual's Medicaid number here:

MCO	
Medicaid #	

2. CONTACT THE MANAGED CARE ORGANIZATION

Contact the MMCO stating that you are making an ACT referral and requesting a level of care assessment. Contact info for many common plans is listed in the table below.

3. WAIT FOR CONFIRMATION FROM THE MANAGED CARE ORGANIZATION

The MMCO will notify the referring provider of the level of care determination within 24 hours.

- If MMCO approves ACT level of care, the MMCO/HARP provides the referring provider with list of in-network ACT teams (see list below). The referring provider submits ACT application with notice of MMCO/HARP level of care authorization and list of in network ACT teams to SPOA.
- If MMCO does not approve ACT level of care, the MMCO/HARP must work with the referring provider and SPOA to develop an alternate service plan that meets the member's clinical, rehabilitation and recovery needs.

**MANAGED CARE ORGANIZATION
CONTACT AND NETWORK INFORMATION**

Plan (please check one)	Contact Information (last updated 4/20/2021)	ACT in Network? (Y/N)	
		RRH	Strong
<input type="checkbox"/> Excellus	Intake Line: 1-844-694-6411 (ask for Outpatient Behavioral Health)	Y	Y
<input type="checkbox"/> Fidelis	Behavioral Health Phone: 1-888-FIDELIS (1-888-343-3547) x16072	Y	Y
<input type="checkbox"/> MVP	Provider Services Line Phone: 1-800-684-9286 BHServices@mvphealthcare.com	N	Y
<input type="checkbox"/> United Health Care	Jason Ross – 1-800-548-6549 x65043 Michelle Cesare – 1-800-578-6549 x57390	N	N
<input type="checkbox"/> Molina Healthcare (Formally Your Care)	Kristine Knoll – 1-315-928-4528 Fax: 1-866-879-4742 <i>Fax ACT referrals and request letter of support</i>	N	N

Note: The list above notes the most common plans but is not all inclusive. MMCO contracts change frequently.

CHECK HERE TO VERIFY THAT THE STEPS ABOVE HAVE BEEN COMPLETED.

Please enter MMCO level of care determination number in the box below:

Level of care determination #	
------------------------------------------	--

Referrals cannot be processed by SPOA unless the steps above have been completed.

***Monroe County ACT Referral
Assertive Community Treatment***

REFERRAL FORM: Part I

ACT services are for individuals who are 18 yrs 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.

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 three 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:

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:

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

REFERRAL FORM: Part II

<p>1: Name of individual requiring services: _____</p>	<p>4: Your name and your relationship to person needing services (for example, parent, friend, or care manager): Name: _____ Relationship: _____</p>
<p>2: Date of Birth: _____ Gender: _____</p>	<p>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: <input type="checkbox"/> yes <input type="checkbox"/> no, if no please explain _____</p>
<p>3: Individual's Insurance (if any). <i>No one will be denied service due to an inability to pay: sliding scale fees are available for individuals without insurance.</i> _____ MEDICAID#: _____</p>	<p>6: Your phone number: _____ Best time to call: _____</p>

Name: _____

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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, social service agency, job, 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 three ACT teams – two 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: 585-279-4903
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

Project ACT
2613 West Henrietta Rd.
Rochester, NY 14623
Telephone: 585-279-4973
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
585-753-2879
FAX: 585-753-2885

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