NIAGARA COUNTY DEPARTMENT OF MENTAL HEALTH & SUBSTANCE ABUSE

SERVICES AOT PROGRAM APPLICATION

APPLICATION GUIDE

- **FOR Assisted Outpatient Treatment (AOT) Program,** please refer to the following pages: 2 - 10. **Pages 4 - 8 must be fully completed and submitted for review.**

    - **Page 2:** AOT Cover Letter explaining application requirements
    - **Page 3:** AOT Program Description
    - **Pages 4 – 6**: AOT Eligibility Form and Application
    - **Pages 7 – 8**: AOT Release of Information Form
    - **Page 9 - 10:** AOT Family / Collateral Contact Consent Form **(*optional but encouraged)***

NIAGARA COUNTY DEPARTMENT OF MENTAL HEALTH AOT PROGRAM APPLICATION

Dear Sir/Madam and/or Referral Source,

Thank you for your interest in the Niagara County Department of Mental Health Assisted Outpatient Treatment (AOT) / Kendra's Law Program. Following this page you will find information on AOT criteria for referral, description of services, and application for services.

If you are the person requesting personal services and completing the application, please do your best to complete all sections. If you are uncertain of the diagnostic section, you may leave this blank, but be sure on the consent form to write in your mental health counselor's, therapist's, doctor's and/or psychiatrist's name and/or agency you attend, or have attended in the past, so we may obtain this information.

For other **referral sources**, please complete ***all*** applicable sections of the application (see application guide on cover of this packet). Please ensure to do all of the following:

- **Write legibly**.
- Place a **line through or write "N/A" in spaces that are not relevant**. ***Do not leave lines/sections just blank***.
- **Write in all information**—***do not write "see attached"*** as others who have authorization to review the application may not have all of the attached documentation to review.

- **Attach the following**:
  - **Supporting documentation of client's CURRENT/ MOST RECENT mental health diagnosis.** Documentation can include an initial psychiatric assessment, psychiatric progress note, treatment plan, discharge summary, etc. listing client's current / most recent diagnosis given or signed off by a psychiatrist, psychologist, psychiatric nurse practitioner, LCSW-R or LCSW. ***Please only include the minimum amount of information necessary.***

  - **Signed consent forms** for all mental health treatment providers (e.g. outpatient mental health provider, any psychiatric hospitals where the client has been treated in the past year, etc) so information can be requested as appropriate to obtain necessary/additional information to determine eligibility for services. *Be sure the correct signature section is completed on the consent. Do NOT sign/witness under the section on the consent that states "Request/Authorization" to withdraw consent". That section is only utilized when a client withdraws Consent. If this section is accidently signed, it invalidates the consent and will delay processing of the application until a valid consent is obtained.*

Please mail or fax the completed application and supporting documentation as noted above to the following:

By Mail: Niagara County Dept. of Mental Health & Substance Abuse Services
5467 Upper Mountain Rd. Suite 200 Lockport, NY 14094

By Fax: (716) 439-7418

Should you have questions, concerns and/or would like more information, please contact us at (716) 439-7412 or at (716) 285-3518 We are happy to assist you.

NIAGARA COUNTY DEPARTMENT OF MENTAL HEALTH AOT PROGRAM APPLICATION

ASSISTED OUTPATIENT TREATMENT (AOT) / KENDRAW'S LAW PROGRAM DESCRIPTION

Consistent with Mental Hygiene Law 9.60 (Kendra's Law), under the oversight of the Director of Community Services, Niagara County operates a program that provides Assisted Outpatient Treatment (AOT). Enhanced monitored comprehensive behavioral health services are provided to individuals with a mental illness who, in view of their treatment history and present circumstances are unlikely to survive safely in the community without supervision.

Frequently Asked Questions

How do I refer someone to the AOT Program?
Contact the Niagara County Department of Mental Health AOT Program at (716) 285-3518. A staff member will respond to your concerns and questions while gathering information from you about your referral.

How will I know if someone is eligible for the AOT Program?
Eligibility may be determined during the telephone screening or further investigation may be needed. If an individual does not meet AOT criteria, referral to other appropriate services will be offered.

What happens after the initial phone call?
A certified social worker will begin an investigation through contacts with the individual, the individual's family members and his/her service providers. The social worker will also gather treatment records from previous and current service providers.

How does the AOT Program help an individual comply with outpatient treatment?
The social worker will work with each individual to achieve and maintain stability and increase life quality through linkage with the most effective and least restrictive services available. The social worker will work with the individual to develop an individualized treatment plan and a written contract. Services may include some or all of the following: mental health treatment, drug and alcohol abuse treatment, hospital in-patient or day treatment, structured housing, case management, vocational programming and crisis services.

How long does an individual remain in the AOT program?
An individual will remain in *active status* in the program until they have demonstrated clear stability and compliance with the treatment plan for an extended period of time. After that, the individual may move into *inactive status*, and a low level of monitoring. After long term compliance with treatment, the AOT case may be closed.

What happens if the individual does not comply with AOT assistance?
After diligent efforts have been exhausted and an individual remains at risk of self-harm or harm to others, a petition for an AOT court order may be initiated with the state Supreme Court system to ensure safety and treatment compliance. The petition, which is a formal statement of facts demonstrating that the person meets the criteria for AOT, must be accompanied by the affidavit of an examining physician. The affidavit must show that the physician examined the person and, with the individual, developed a treatment plan, prior to the filing of the petition, and that the individual meets the programmatic criteria.

To whom is the court order directed?
The court order is directed to both the individual receiving AOT and the local director of the AOT program. The order will require the individual to accept the treatment deemed necessary by the court, and will require the local director to furnish such treatment through local service providers. This provides greater accountability of service providers in serving the consumer.

How long does the AOT court order remain in effect?
The initial court order is effective for up to 1 year from the date of the order. The order can be extended for successive periods of up to 1 year each, but any application to extend AOT requires a showing that the person continues to meet all of the AOT criteria.

ASSISTED OUTPATIENT TREATMENT (AOT) / KENDRA'S LAW PROGRAM
For adults ages 18 and older
Only complete this section if making referral for AOT/Kendra's Law status. (Pages 5 - 9)

CLIENT NAME:

☐ Diagnosed with a mental illness (specify the following)

1. Most recent DSM diagnosis	2. Date of diagnosis	3. Name/credentials of person who made diagnosis

AND

☐ Is unlikely to survive in the community without supervision, based on a clinical determination **(explain):**

AND

☐ Has a history of non-compliance with treatment for mental illness which has led to either:
☐ TWO psychiatric hospitalizations (or forensic incarcerations) within the preceding THREE years (if known, list dates, hospitals & circumstances):

OR

☐ at least ONE act of violence toward self or others, or threats of serious physical harm to self or others, within the preceding FOUR years (if known, list dates & circumstances):

AND

☐ Is unlikely to accept treatment recommended/voluntarily participate in treatment plan (state history/current refusals):

AND

☐ Is in need of AOT to avoid a relapse or deterioration which could lead to serious harm to self or others (specify):

AND

☐ Will likely benefit from AOT (specify anticipated outcome):

AND

☐ AOT is **LEAST RESTRICTIVE** treatment alternative (specify):

NIAGARA COUNTY DEPARTMENT OF MENTAL HEALTH AOT PROGRAM APPLICATION
AOT APPLICATION CONTINUED…

☐ **Reason for application / presenting problem:**

☐ **Individual is currently in crisis and may need immediate Mental Health Intervention.** ***Refer this individual to the Niagara County Crisis Hotline immediately (716) 285-3515.***

CLIENT INFORMATION			
For NCDMH use—client ID #			
First Name	**Middle Initial**	**Last Name**	
Social Security #	**Date of Birth**	**Age**	**Gender** ☐ Male ☐ Female ☐ Transgender
Current Street Address	**Town**		**Zip**
Home Phone #	**Cell Phone #**	**Work / Other Phone #**	
Health Insurance: ☐ Yes ☐ No ☐ Unknown ☐ **Application Pending for**: ☐ Medicaid ☐ Medicare ☐ Managed Care ☐ Other ***Specify pending date of approval***:			
If Medicaid – provide #	**Medicaid Active**? ☐ Yes ☐ No	**If no, eligible**? ☐ Yes ☐ No ☐ Unknown	
If Medicare – provide #	**Other Insurance Type:** **Policy Holder:** **Policy #**		
Current benefits ☐ SSI ☐ SSD ☐ Survivor's ☐ Public Assistance ☐ Unemployment ☐ Earned Income ☐ None ☐ Unknown			
Ethnicity (check all that apply) ☐ White/Non-Hispanic ☐ African American ☐ Latino ☐ Hispanic ☐ Native American/Alaskan ☐ Asian ☐ Unknown ☐ Other (*specify):*			
Brief physical description (approximate height, weight, hair / eye color, identifying features – i.e. piercings, tattoos, etc.)			
Special Needs & Preferences (physical, medical, visual, hearing, cultural/religious, language, writing, reading, developmental disability) (*specify):* **Are services required in a language other than English?** ☐ No ☐ Yes *If yes, specify language*:			
Marital Status ☐ Single never married ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Unknown ☐ Other *(specify)*			
Living Situation ☐ Unknown ☐ Alone ☐ With Child(ren), # of persons in home: _____ ☐ With other family / friends, # of persons in home: _____ ☐ Homeless/Streets ☐ Emergency Shelter ☐ OMH Facility *(specify type)* ☐ Hospital *(specify type)* ☐ OCFS Facility *(specify type)* ☐ OASAS Facility *(specify type)* ☐ Jail/Correctional Facility *(specify current charges/ convictions and release date)* ☐ Other *(specify)*			

Is the living environment safe? ☐ Yes ☐ No ☐ Unknown

Are there weapons in the home? ☐ Unknown ☐ No ☐ Yes ***If yes, specify type***:

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TREATMENT, SERVICES AND HISTORY				
Services	**Past 30 days Or Ongoing (√)**	**Past Year (√)**	**Prior to 1 year ago (√)**	**No History (√)**
Psychiatric Inpatient ***(list # of times if known):***	☐	☐	☐	☐
Hospital Psychiatric Emergency Room, NO ADMISSION ***(list # of times if known):***	☐	☐	☐	☐
Emergency Mental Health / Crisis Services	☐	☐	☐	☐
Mental Health Outpatient Treatment ***(agency / provider name & next appoint date /time)*:**	☐	☐	☐	☐
Residential Program ***(specify):***	☐	☐	☐	☐
Primary Medical Care	☐	☐	☐	☐
Medical Hospitalization ***(list # of times if known)***	☐	☐	☐	☐
Alcohol / Substance Abuse Treatment – ***(agency):***	☐	☐	☐	☐
AOT program involvement	☐	☐	☐	☐
☐ Case / Care Management / ☐ Health Home - ***(specify):***	☐	☐	☐	☐
Developmental Disability	☐	☐	☐	☐
☐Probation ☐Parole ☐ Treatment Court ☐ Legal involvement *(specify)*	☐	☐	☐	☐
Dept. of Social Services Protective Services - ☐Child / ☐ Adult	☐	☐	☐	☐
Other ***(specify)*:**	☐	☐	☐	☐

Risk and Safety Concerns *(Check all that apply–current & history of):* ☐ suicidal ideation ☐ suicide attempts ☐ self-harm ☐ homicidal ideation ☐ violence/assault ☐ alcohol/substance abuse ☐ fire setting/arson ☐ Other *(specify)*

Individual identified as high risk by: ☐ Behavioral Health Organization (BHO) ☐ Health Home ☐ N/A

Valid Reporter/Petitioner Name:

☐ Roommate ☐ Parent ☐ Spouse ☐ Adult Child ☐ Sibling ☐ Other (specify):
☐ Residence ☐ Hospital ☐ Agency ☐ Psychiatrist ☐ Parole ☐ Probation ☐ DSS ☐ DCS

Reporter's Title (if appropriate):
Agency / Address:
City **Zip**
Phone:

Application Completed by or check if same as above ☐:
Name: **Title**:

Agency / Address:
City **Zip**
Phone:

Date Completed:

I CERTIFY UNDER PENALTY OF LAW, THAT THE INFORMATION I SUBMIT IN THIS APPLICATION, TO BE CORRECT TO THE BEST OF MY KNOWLEDGE.

Signature: _____

NIAGARA COUNTY DEPARTMENT OF MENTAL HEALTH AOT PROGRAM APPLICATION

AUTHORIZATION FOR RELEASE OF INFORMATION	Patient Name (Last, First, M.I.)
	Sex Date of Birth
	Facility/Agency Name: **Niagara County Dept of Mental Health & Substance Abuse Services**

This authorization must be completed by the patient or his/her personal representative to use/disclose protected health information (for other than treatment, payment, or health care operations purposes), in accordance with State and federal laws and regulations. A separate authorization is required to use or disclose confidential HIV related information.

PART 1: Authorization to Release Information

Description of Information to be Used/Disclosed (PLEASE CHECK AS APPROPRIATE):
☒ Identifying Information ☒Presence in treatment/services ☒ Information necessary to engage in services ☒ Dates and locations of Psychiatric hospitalizations and discharge summaries ☒ Medical Information/Concerns/Medications ☒ Lethality/Risk Concerns ☒Diagnosis/Prognosis/Progress in Treatment/Services ☒Behavioral/Mental Health Information ☒ Substance use/abuse Information ☒ Legal/Criminal Justice Status including dates and locations of arrests and incarcerations
☐**Other (identify):** _____

Purpose or Need for Information: Referral to Assisted Outpatient Treatment (AOT) Program and AOT Court Petition Process.
1. This information is being requested: (PLEASE CHECK ONE)
☒ by the individual or his/her personal representative; or ☐ By Other (please describe) _____
1. The purpose of the disclosure is (PLEASE DESCRIBE): ☒Continuity of Care ☒Coordination of Services
☒ Facilitate Referrals/Linkage with Needed Services ☒AOT Court Order Process ☐**Other (identify):**

From/To: Name, Address, & Title of Person/ Organization/Facility/Program Disclosing Information and To which Disclosure is to be Made ***NOTE:*** *If the same information is to be disclosed to multiple parties for the same purpose, for the same period of time, this authorization will apply to all parties listed here.*	**To/From:** Name, Address, & Title of Person/Organization/ Facility/Program to Which this Disclosure is to be Made and which is Disclosing Information. ***NOTE:*** *If the same information is to be disclosed to multiple parties for the same purpose, for the same period of time, this authorization will apply to all parties listed here.*
Name: Niagara County Dept. of Mental Health & Substance Abuse Svs 5467 Upper Mountain Rd. Suite 200, Lockport, NY 14094; Phone: (716) 285-3518 Fax: 278-8130	**Name:**

A. I hereby permit the use or disclosure of the above information to the Person/Organization/Facility/Program (s) identified above. I understand that:

1. Only this information may be used and/or disclosed as a result of this authorization.
2. This information is confidential and cannot legally be disclosed without my permission.
3. If this information is disclosed to someone who is not required to comply with federal privacy protection regulations, then it may be redisclosed and would no longer be protected.
4. I have the right to revoke (take back) this authorization at any time. My revocation must be in writing on the form provided to me by (**Niagara County Dept. of Mental Health & Substance Abuse Services**), shown below. I am aware that my revocation will not be effective if the persons I have authorized to use and/or disclose my protected health information have already taken action because of my earlier authorization.
5. I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from the New York State Office of Mental Health, nor will it affect my eligibility for benefits.
6. I have a right to inspect and copy my own protected health information to be used and/or disclosed (in accordance with the requirements of the federal privacy protection regulations found under 45 CFR §164.524.

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Facility/Agency Name: **Niagara County Dept of Mental Health & Substance Abuse Services**	Patient's Name (Last, First, MI)	ID #

B. Periodic Use/Disclosure: I hereby authorize the periodic use/disclosure of the information described above to the person/organization/facility/program identified above as often as necessary to fulfill the purpose identified above.
My authorization will expire:
☒ When I am no longer receiving services from **Niagara County Dept. of Mental Health & Substance Abuse Services**
☐ Other (specify) _____

C. Patient Signature: I certify that I authorize the use of my health information as set forth in this document.

_____ _____
Signature of Patient or Personal Representative Date

_____
Patient's Name (Printed)

_____
Personal Representative's Name (Printed)

_____
Description of Personal Representative's Authority to Act for the Patient (*required if Personal Representative signs Authorization*)

D. Witness Statement/Signature: I have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the patient and/or the patient's personal representative.

WITNESSED BY: _____
Staff person's name and title
Authorization provided to: _____ Date: _____

To be Completed by Facility:
Signature of Staff Person Using/Disclosing Information : _____

Title: _____

Date Released: _____

PART 2: Revocation of Authorization to Release Information

I hereby revoke my authorization to use/disclose information indicated in Part I, to the Person/Organization/Facility/Program whose name and address is:
_____
_____

I hereby refuse to authorize the use/disclosure indicated in Part I, to the Person/Organization/Facility/Program whose name and address is: _____
_____

_____ _____
Signature of Patient or Personal Representative Date

_____
Patient's Name (Printed)

_____
Personal Representative's Name (Printed)

_____
Description of Personal Representative's Authority to Act for the Patient (*required if Personal Representative signs Revocation of Authorization*)

NIAGARA COUNTY DEPARTMENT OF MENTAL HEALTH AOT PROGRAM APPLICATION

FAMILY / COLLATERAL CONTACT CONSENT FORM (2 pages):

AUTHORIZATION FOR RELEASE OF INFORMATION	Patient Name (Last, First, M.I.)
	Sex Date of Birth
	Facility/Agency Name: **Niagara County Dept of Mental Health & Substance Abuse Services Assisted Outpatient Treatment Program**

This authorization must be completed by the patient or his/her personal representative to use/disclose protected health information (for other than treatment, payment, or health care operations purposes), in accordance with State and federal laws and regulations. A separate authorization is required to use or disclose confidential HIV related information.

PART 1: Authorization to Release Information

Description of Information to be Used/Disclosed (PLEASE CHECK AS APPROPRIATE):
☒ Identifying Information ☒Presence in treatment/services ☒ Information necessary to engage in services
☐ Medical Information/Concerns ☐ Lethality/Risk Concerns ☐Diagnosis/Prognosis/Progress in Treatment/Services
☐Behavioral/Mental Health Information ☐ Substance use/abuse Information ☐ Legal/Criminal Justice Status
☐**Other (identify):** _____

Purpose or Need for Information
1. This information is being requested: (PLEASE CHECK ONE)
☒ by the individual or his/her personal representative; or ☐ By Other (please describe) _____
2. The purpose of the disclosure is (PLEASE DESCRIBE): ☒Continuity of Care ☒Coordination of Services
☒ Facilitate Referrals/Linkage with Needed Services ☐**Other (identify):** _____
_____

From/To: Name, Address, & Title of Person/ Organization/Facility/Program Disclosing Information and To which Disclosure is to be Made ***NOTE:*** *If the same information is to be disclosed to multiple parties for the same purpose, for the same period of time, this authorization will apply to all parties listed here.*	**To/From:** Name, Address, & Title of Person/Organization/ Facility/Program to Which this Disclosure is to be Made and which is Disclosing Information. ***NOTE:*** *If the same information is to be disclosed to multiple parties for the same purpose, for the same period of time, this authorization will apply to all parties listed here.*
Name: Niagara County Dept. of Mental Health AOT Program 5467 Upper Mountain Rd. Suite 200, Lockport, NY 14094; Phone: (716) 439-7412; Fax: (716) 439-7418	**Family / Collateral Contact(s):**

A. I hereby permit the use or disclosure of the above information to the Person/Organization/Facility/Program (s) identified above. I understand that:

7. Only this information may be used and/or disclosed as a result of this authorization.
8. This information is confidential and cannot legally be disclosed without my permission.
9. If this information is disclosed to someone who is not required to comply with federal privacy protection regulations, then it may be redisclosed and would no longer be protected.
10. I have the right to revoke (take back) this authorization at any time. My revocation must be in writing on the form provided to me by (**Niagara County Dept. of Mental Health**), shown below. I am aware that my revocation will not be effective if the persons I have authorized to use and/or disclose my protected health information have already taken action because of my earlier authorization.
11. I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from the New York State Office of Mental Health, nor will it affect my eligibility for benefits.
12. I have a right to inspect and copy my own protected health information to be used and/or disclosed (in accordance with the requirements of the federal privacy protection regulations found under 45 CFR §164.524.

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Facility/Agency Name: **Niagara County Dept of Mental Health Assisted Outpatient Treatment Program**	Patient's Name (Last, First, MI)	ID #

B. Periodic Use/Disclosure: I hereby authorize the periodic use/disclosure of the information described above to the person/organization/facility/program identified above as often as necessary to fulfill the purpose identified above.
My authorization will expire:
☒When I am no longer receiving services from **Niagara County Dept. of Mental Health Assisted Outpatient Treatment Program**
☐ Other (specify) _____

C. Patient Signature: I certify that I authorize the use of my health information as set forth in this document.

_____ _____
Signature of Patient or Personal Representative Date

_____
Patient's Name (Printed)

_____
Personal Representative's Name (Printed)

_____
Description of Personal Representative's Authority to Act for the Patient (*required if Personal Representative signs Authorization*)

D. Witness Statement/Signature: I have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the patient and/or the patient's personal representative.

WITNESSED BY: _____
Staff person's name and title
Authorization provided to: _____ Date: _____

To be Completed by Facility:
Signature of Staff Person Using/Disclosing Information : _____

Title: _____

Date Released: _____

PART 2: Revocation of Authorization to Release Information

I hereby revoke my authorization to use/disclose information indicated in Part I, to the Person/Organization/Facility/Program whose name and address is:
_____
_____

I hereby refuse to authorize the use/disclosure indicated in Part I, to the Person/Organization/Facility/Program whose name and address is: _____
_____

_____ _____
Signature of Patient or Personal Representative Date

_____
Patient's Name (Printed)

_____
Personal Representative's Name (Printed)

_____
Description of Personal Representative's Authority to Act for the Patient (*required if Personal Representative signs Revocation of Authorization*)