COUNTY OF SUFFOLK

STEVE LEVY
SUFFOLK COUNTY EXECUTIVE

DEPARTMENT OF HEALTH SERVICES

HUMAYUN J. CHAUDHRY, D.O., M.S.
Commissioner

CAMERA

DESCRIPTION OF SERVICES

In order to be eligible for Bridger, SCM, ICM or ACT team services an individual must have a primary diagnosis of a major mental illness as described in the DSM IV. The primary diagnosis cannot be drug/alcohol, mental retardation, organic disorder or developmental disability. The target population is the serious and persistently mentally ill client (SPMI) whose diagnosable mental illness significantly impairs his/her ability to function in the community without supports.

BRIDGER:
These services are generally applied for when a client is inpatient and preparing for discharge into the community, approximately 1 to 2 weeks prior to discharge. Bridger services are also used for clients already living in the community who require short-term assistance. The primary goal of these services is to help facilitate the transition of individuals from an inpatient status to the community with full use of community services.

TRADITIONAL INTENSIVE CASE MANAGEMENT SERVICES (ICM):
These services share the same goals as SCM however are intended for high risk and heavy users of mental health services who may be homeless, MICA, MI/MR and/or forensic clients who may not be linked to treatment programs. ICM services provide a minimum of four face-to-face visits per month with caseloads at 1:12.

BLENDED AND FLEXIBLE INTENSIVE AND SUPPORTIVE CASE MANAGEMENT:

In 2001 changes in case management provided for the more flexible services of a blended team model. Services are provided by a team of ICMs and SCMs with shared caseloads. ICMs on the team provide clinical supervision to SCMs. All clients on the blended team must receive a minimum of two face-to-face visits per month. The blended team approach allows for clients served by the team to receive additional visits as required without the need for a change in level of service. ICM caseloads are 1:12, SCM caseloads are 1:30. The decision for placement on the blended team is made by CAMERA and/or the case management agency.

C.A.M.E.R.A. UNIT
North County Complex, Building C928, 725 Veterans Memorial Highway, P.O. Box 6100, Hauppauge, NY 11788
(631) 853-2995 FAX: (631) 853-6451

ASSERTIVE COMMUNITY TREATMENT TEAM (ACT):

These services share the same goals as ICM however are intended for those clients most at risk. Priority is given to individuals with continuous high service needs that are not being met in more traditional service settings. This would include clients with serious functional impairments which prevent them from consistently performing practical daily living tasks required for basic adult functioning in the community without significant support, inability to sustain employment and inability to maintain a safe living situation. These clients are generally high users of services including frequent acute psychiatric hospitalization, emergency and/or crisis services and criminal justice involvement. Intensive community-based, skills training, support and treatment services are provided by an interdisciplinary team of mental health professionals. ACT teams provide a minimum of six face-to-face visits per month, three of which may be with collaterals.

SERVICE DOLLARS:

Service dollars are available.

HIPPA:

In response to new Federal HIPPA guidelines, the client's authorization for release of confidential information will expire either 180 days from the date of signature, when the client is no longer receiving services through CAMERA or if cancelled by the client. A CAMERA Application Up-Date form has been developed to be used in cases where the client's most recent application was completed within the previous 12 months.

All referrals for case management must be on the CAMERA application

Mail or Fax to:
Suffolk County Case Management
CAMERA Unit
Suffolk County Division of Community Mental Hygiene
North County Complex, Building C928
P. O. Box 6100
Hauppauge, New York 11788
Phone No. (631) 853-2995 Fax (631) 853-6451

Rev 2/20/08

COUNTY OF SUFFOLK

Steve Levy
SUFFOLK COUNTY EXECUTIVE

DEPARTMENT OF HEALTH SERVICES
Division of
COMMUNITY MENTAL HYGIENE SERVICES

HUMAYUN J. CHAUDHRY, DO, MS
COMMISSIONER
THOMAS O. MACGILVRAY, CSW, CASAC
DIRECTOR

INSTRUCTIONS FOR COMPLETION OF CASE MANAGEMENT/ACT TEAM APPLICATIONS

Do not detatch until ready to FAX application

Complete pages 1 – 5 for case management and ACT Team. **(PLEASE TYPE OR PRINT NEATLY WITH BLACK INK)**

- Consent for Release of Information must be **signed** and **dated** by both the applicant and the witness. For ACT Referrals only – if you cannot obtain client's signature on consent, please submit application with an explanation.

- **Attach Most Recent Psychiatric Evaluation and Psycho-Social Assessment.**

- Please list the **specific number** of psychiatric hospitalizations by year, not just "multiple" or a checkmark.

Application will be reviewed and assessed for eligibility and services needed. An **incomplete application** will delay assessment for services.

All referrals for Case Management/ACT Team must be faxed or mailed to:

CAMERA Unit
Suffolk County Division of Community Mental Hygiene Services
North County Complex Building C928
P.O. Box 6100
Hauppauge, New York 11788
Phone # (631) 853-2995 FAX # (631) 853-6451

COUNTY OF SUFFOLK

STEVE LEVY
SUFFOLK COUNTY EXECUTIVE

DEPARTMENT OF HEALTH SERVICES
HUMAYUN J. CHAUDHRY, DO, MS
COMMISSIONER
DIVISION OF COMMUNITY MENTAL HYGIENE SERVICES
THOMAS O. MACGILVRAY, CSW, CASAC
DIRECTOR

APPLICATION FOR CASE MANAGEMENT SERVICES

Level of Service Requested: Bridger ☐ SCM ☐ ICM ☐ ACT ☐

Referral Source _____

Address _____

_____

Tel # _____ Fax # _____

Contact Person _____

Application Date:

_____

Name
Last _____ First _____ MI___

Discharge Date:

_____
(If applicable)

Address_____

City _____ State ___ Zip _____Tel#_____

Soc. Sec.# _____ D.O.B_____ Male____ Female____

SECTION I

1. Applicant's primary diagnosis code # as per DSM III-R or DSM IV _____.___ _____.___

   Diagnosis Description:_____

   Additional Codes: Axis I _____.___ Axis II_____.___ Axis III _____ Axis IV____ Axis V_____

2. Psychotropic Medications _____

   _____

3. Outpatient Treatment Program/Clinic_____

   Address_____ Tel #_____

   Date of next appointment _____ Time of appointment_____

4. **NUMBER IN EACH YEAR** of Psychiatric Hospitalizations: **(Do not use Checkmarks or Multiple)**

   Before 2003____ 2004____ 2005____ 2006____ 2007____ 2008____ 2009____

5. **Most recent or current** Psychiatric Hospitalization:

   Hospital Name: _____ From:_____ To:_____

Applicant Name: _____

5. EMERGENCY CONTACT

Name _____

Address _____

Tel # _____ Relationship _____

7. 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 # _____

8. **If applicant is currently receiving or has made application for the following benefits, indicate status and amount.** ☐ **Active** ☐ **Inactive** ☐ **Pending**

☐ PA ☐ SSI ☐ SSD ☐ VA Other:_____

$_____ $_____ $_____ $_____ $_____

9. Type of Housing: Com. Res. ____ Adult Home ____ Rm&Bd ____ Supported Housing ____
DSS Emergency Housing ____ Own Home/Apt. ____ Sober House____ Other_____

10. **If applicant has children, list names, dates of birth and indicate whether living with the applicant.**

Name:	*Date of Birth:*	Living with Applicant:
_____	_____	☐ Yes ☐ No
_____	_____	☐ Yes ☐ No
_____	_____	☐ Yes ☐ No
_____	_____	☐ Yes ☐ No
_____	_____	☐ Yes ☐ No
_____	_____	☐ Yes ☐ No
_____	_____	☐ Yes ☐ No

Applicant Name_____

SECTION II: PRIMARY NEEDS ASSESSMENT

Based upon your knowledge of the applicant, to what extent will (s)he need help in the following areas in order to maintain herself/himself in the community?
Please check appropriate level of needs and provide explanation below.

	Severe	Moderate	Mild	No Problem	Unknown
Mental Health	☐	☐	☐	☐	☐
Physical Health	☐	☐	☐	☐	☐
Alcohol/ Substance Abuse	☐	☐	☐	☐	☐
Housing	☐	☐	☐	☐	☐
Financial	☐	☐	☐	☐	☐
Family/Friends/Social	☐	☐	☐	☐	☐
Activity of Daily Living Skills	☐	☐	☐	☐	☐
Employment/Vocation	☐	☐	☐	☐	☐
Education	☐	☐	☐	☐	☐
Legal Problems	☐	☐	☐	☐	☐

SECTION III: ASSESSMENT OF PRIMARY MEDICAL NEEDS

Medical Physician's Name: _____ Tel # _____

Address _____

☐ Physical health problems requiring regular health care _____

_____

☐ Physical Handicap _____

☐ Visual/Hearing Impairment _____

☐ Mental Retardation _____

☐ Alcohol/Substance Abuse _____

☐ Current Medications _____

☐ None ☐ Unknown

EXPLANATION OF NEEDS ASSESSMENTS AS INDICATED IN SECTIONS II AND III ABOVE

_____

_____

_____

_____

_____

_____

Applicant Name_____

SECTION IV - FORENSIC

☐ On parole: _____ From:_____ To:_____

Parole officer: _____ Phone #: _____

☐ On probation: _____ From:_____ To:_____

Probation officer: _____Phone #: _____

☐ Order of Protection: _____ From:_____ To:_____

☐ CPL order: _____

☐ Conditional Release:_____ ☐ Special Release:_____

☐ None ☐ Unknown

ASSAULTIVE OR VIOLENT BEHAVIOR - EXPLAIN

☐ Has threatened physical violence to:

- ☐ Self: _____ Date:_____
- ☐ Others: _____ Date:_____
- ☐ Unknown ☐ Not applicable

☐ Has attempted or physically harmed:

- ☐ Self: _____ Date:_____
- ☐ Others: _____ Date:_____
- ☐ Unknown ☐ Not applicable

☐ Has damaged property which belongs to:

- ☐ Self: _____ Date:_____
- ☐ Others: _____ Date:_____
- ☐ Unknown ☐ Not applicable

☐ Has committed: ☐Rape ☐Sexual Assault ☐Child Sexual/Physical Abuse

☐ Other (explain): _____

☐ Has been a victim of: ☐Rape ☐Sexual Assault ☐Child Sexual/Physical Abuse

☐ Other (explain): _____

☐ **Current/past** Child Protective Services Involvement ☐Yes ☐No Date_____

Explain_____

Applicant Name: _____

SECTION V: APPLICANT APPOINTMENTS

Please list any appointments applicant has within the next 4 weeks which may require assistance:

LOCATION	DATE	TIME	CONTACT PERSON	TEL #

Applicant must sign the Consent for Release of Information.

CONSENT FOR RELEASE OF INFORMATION

I accept this referral for Case Management services and hereby authorize the periodic release of information necessary to arrange for these services to any Case Management, Mental Health treatment agency or other agencies that may provide services for me. I understand that the information to be released is confidential and protected from disclosure. I also understand that I have the right to cancel my permission for release of information at any time.

My consent to release information to the CAMERA Unit and to any Case Management, Mental Health treatment agency or other agencies that may provide services for me will expire one year from this date or when I am no longer receiving services from such organization.

Signature of Applicant	Date Signed	Signature of witness	Title	Date Signed
_____	_____	_____	_____	_____

PLEASE ATTACH ADDITIONAL PAGES IF NEEDED

PLEASE FORWARD COMPLETED APPLICATION WITH CURRENT CLINICAL ASSESSMENT TO:

Suffolk County Case Management
CAMERA UNIT
Suffolk County Division of Community Mental Hygiene
North County Complex, Building C928
P. O. Box 6100
Hauppauge, New York 11788
PHONE (631) 853-2995 FAX (631) 853-6451