A SPOA application does not need to be submitted for the Crisis Respite and the Hospital Discharge Programs. Contact Sheri-Ann Best (Mental Health Association), at 516 489-2322, ext 1318.

Hospital Discharge Planning

The philosophy of this program is to maintain hospital stabilization by the organization and utilization of appropriate community resources. The goal is to access these services to achieve long-term symptom management or recovery. The purpose is to ensure shorter and fewer psychiatric hospital stays through collaborative discharge planning with hospital staff, patients and families. When a child is discharged, ongoing contact with the family can be provided to link them to essential community resources. Discharge plans are developed through the collaboration of our Coordinator, the hospital, mental health professionals and families.

Children’s Crisis Respite Program

Children’s Crisis Respite Program was developed as a part of an overall movement toward a community-based system of care for children and adolescents, and is an integral part of the Emergency Psychiatric System of Nassau County. The purpose of the program is to provide short-term residential care for children and adolescents in severe psychiatric crisis through the use of scattered-site crisis respite beds. The philosophy of the program is to maintain those at risk for psychiatric hospitalization in the community by organizing more appropriate resources. The goal is to intervene quickly in crisis situations and access a crisis respite bed in an effort towards crisis stabilization.

SPOA IN HOME PROGRAMS

Send completed application and a signed Release of Information from the Parent/Guardian to:

SPOA Unit/Children’s Services
Department of Mental Health, Chemical Dependency and Developmental Disabilities Services
60 Charles Lindbergh Boulevard,
Uniondale, New York 11553
(516) 227-7057
FAX (516) 227-7076

You will need to include supporting documentation with your application:

- Psychosocial/Developmental History (required)
- Psychiatric Evaluation (required) DSM DX, Meets criteria for SED, GAF 50 or less.
- Educational/Vocational Summary
- Discharge or Treatment Summary (Hospital or Residential)
- Psychological Evaluation
- Individualized Educational Plan (IEP)
- Probation Reports
- Medical Reports

SPOA
(Single Point of Access)

CHILDREN’S IN HOME PROGRAMS

The Single Point of Access (SPOA) simplifies and coordinates the process of linking children with severe social, emotional and behavioral disorders and their families to the services that can assist in meeting their needs.

County of Nassau

Department of Mental Health, Chemical Dependency and Developmental Disabilities Services
60 Charles Lindbergh Boulevard,
Uniondale, New York 11553
(516) 227-7057
FAX (516) 227-7076

NassauCountyMentalHealth@mail.co.nassau.ny
Case Management Program

*ICM/SCM*

Case management is a community support service that ensures a well-coordinated and flexible system of care for children and youth with serious emotional disturbances and their families. These youngsters and their families need supports and services including mental health, special education, vocational services, health care, recreation and social services. Case management services play a major role in linking clients with needed services, advocating, helping families navigate complex systems, and providing on-site crisis intervention and skills teaching.

The objective of case management is to maintain the child with a serious emotional disturbance in his/her natural environments: family, school, and community. Case Managers access and coordinate the supports and services necessary to help children and adolescents live successfully at home and in the community. The Case Manager works closely with the child’s family and coordinates the services of mental health and related service providers with those of school-based professionals. Services are based on the specific needs and desires of the child and his or her family and are made available for as long as necessary.

Family Advocate Program

Support is provided to families of high risk, seriously emotionally disturbed children and youth by Family Advocates (parents of youth with social, emotional and/or behavioral disorders who have firsthand experience with the issues facing parents trying to negotiate the various child-serving systems). Team approach empowers parents to become strong advocates for their children, provides information and advice about child-serving systems, provides intensive support to parents, and helps families develop more natural support systems. The program offers both individual and weekly group support to families.

Coordinated Children’s Service Initiative

*CCSI*

The CCSI program works directly with youth served in multiple systems and who are at risk of placement in at least one of these systems. The goal is to reduce the rate of residential placement and optimize their functioning in the community. The population is between 5-17 years of age and are receiving an intensive level of services from at least two systems (i.e. mental health, education, social services and probation) and are at risk of placement and/or long-term hospitalization in at least one of the systems.

CCSI provides intensive care coordination, family-driven, strengths-based service planning, advocacy/trouble-shooting, and parenting skills training. CCSI uses an Individualized Care approach focusing on the child and family’s strengths allowing the family to make decisions about what services are needed. A variety of support services are available to assist the family in helping their child function successfully while living in the community.

Clinical Care Coordination Team

*CCCT*

The Clinical Care Coordination Team (CCCT) provides an alternative treatment approach for high-risk children and youth for whom traditional outpatient services haven’t been effective. The target population is 5 to 17 year old children who have a history of continually refusing treatment, and who present a high risk for hospitalization and/or residential placement. CCCT provides in-home individual and family therapy, as well as psychiatric consultation, evaluation and monitoring. The program partners with the family to develop a strengths-based, family-driven plan of care, to advocate within the service systems for appropriate services, and to help ensure effective collaboration and coordination among all service providers.

Home and Community Based Services

*Medicaid Waiver*

The OMH HCBS waiver program serves children and adolescents with serious emotional disturbances between the ages of 5 and 18 years of age who are at risk for a psychiatric hospitalization or a residential placement. The child must be at imminent risk for placement yet capable of being cared for in the community if provided appropriate services. The child’s income and resources (without reference to parents) must meet Medicaid eligibility.

The goals of the Waiver program are to shift the focus of care to the community and decrease the need for placements in intermediate inpatient and RTF levels of care; to increase the array of Medicaid reimbursable community based services that would have been available only in an RTF or intermediate inpatient facility; to focus upon clinical determinations of needed services and supports rather than financial determinations; to grant families a choice of providers where and when possible; to serve children with complex mental health needs in their homes and communities; and to use an individualized care service delivery approach when serving these children and families. The program coordinates individually tailored plans of care, which are designed to meet the needs of children and their families by using their strengths and building a supportive home and community based environment. The services include; Individualized Care Coordination, Intensive In-Home Services, Respite Care, Family Support Services, Crisis Response Services, Skill Building Services.