**NYS OMH Assertive Community Treatment (ACT)**
**Program Guidelines Waiver for Psychiatric Coverage Request Form**
**November 2018**

**Date Request Submitted:**

**Name of ACT Team Agency**: **Name of ACT Team:**

**Contact Person Name and Title**:

**Contact Person Phone**: **Contact Person E-Mail**:

**Overview of Waiver Process:**

- ACT Team completes the NYS ACT Program Guidelines Waiver Request Form.
- ACT Team submits completed form via email to your NYS Office of Mental Health (OMH) ACT Field Office (FO) Liaison.
- FO staff will review the information provided and contact your agency if further information is needed.
- FOs will share submitted waivers with LGU/SPOA.
- FO, Central Office, and OMH Chief Medical Officer will make a final determination.
- OMH will issue a letter approving or denying the waiver request.
- FOs will share approval/denial letters with LGU/SPOA.
- If for any reason during the approved timeframe the agency is no longer meeting all of the Waiver Requirements as listed in the ACT Program Guidelines Waiver for Psychiatric Coverage Memo, OMH reserves the right to revoke the agency's waiver approval at any time.

**Complete the following:**

1. Provide details on current Psychiatric Coverage, including current PNP staffing.

2. Provide detailed reason for needing a waiver of ACT Program Guidelines for Psychiatric Coverage.

3. Provide details on efforts undertaken to meet existing ACT Program Guidelines for psychiatric time. Include time frames of psychiatric vacancies.

4. Provide plans for future efforts for hiring efforts for psychiatrists.

5. Describe how the agency will ensure highly complex psychopharmacology needs will be met if waiver is approved.

| ACT Program Guidelines Waiver for Psychiatric Coverage Request Form<br>*To affirm ACT Team request and compliance with each requirement, check box in left column.* | |
|---|---|
| ☐ | My ACT Team is requesting:<br><br>☐ Split time with a psychiatrist and a PNP to total scheduled psychiatric coverage - at a minimum of 0.68<br>FTE for a 68 team and 0.48 FTE for a 48 team.<br>**Provide number of minimum hours covered by PNP** Click or tap here to enter text.**and by Psychiatrist** Click or tap here to enter text.<br>**OR**<br><br>☐ PNP on the team, who will be scheduled 1.0 FTE for psychiatric coverage, and who will receive supervision from a Psychiatrist through a supervisory agreement/contract (see ACT Program Guideline Waiver Requirements. |
| ☐ | All ACT Program Guideline Waiver Requirements have been reviewed and will be followed as per the ACT Program Guidelines Waiver for Psychiatric Coverage Memo issued November, 2018. |
| ☐ | Attached is the supervisory agreement for the PNP (ONLY needed for option b.). |
| ☐ | Our ACT team has received sign off from provider leadership to submit this request, please provide name and title: |

**Certification and Acknowledgement**

I certify, on behalf of my agency, that all information contained in this request is accurate. I have read the ACT Program Guidelines Waiver for Psychiatric Coverage Memo and certify that, if approved, our agency will follow all ACT Program Guideline Waiver Requirements.

| _____ | _____ | _____ |
|---|---|---|
| ACT Team Supervisor (print) | Signature | Date |

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**For Field Office Use ONLY**

Request Received:

Additional information requested (with dates):

Date Sent to LGU/SPOA:

NYS OMH Field Office supports request: ☐ Yes ☐ No