



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

Date Request Submitted: Click here to enter text. Click or tap to enter a date.

Name of ACT Team Agency: Click here to enter text. **Name of ACT Team:** Click here to enter text.

Contact Person Name and Title: Click here to enter text.

Contact Person Phone: Click here to enter text. **Contact Person E-Mail:** Click here to enter text.

Overview of Waiver Extension Process:

- ACT Team completes the NYS ACT Program Guidelines Waiver Extension 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 will contact your agency if further information is needed.
- FOs will share submitted extension waivers with Local Government Unit/Single Point of Access (LGU/SPOA).
- FO, Central Office, and OMH 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 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.
- If there are any changes to coverage during the approved time, you must notify your FO liaison.

Please complete the questions below to apply for an extension to your existing Psychiatric Nurse Practitioner Waiver.

1. Has there been any change in psychiatrist or Psychiatric Nurse Practitioner coverage (hours designated, staffing change) over the last year? Click or tap here to enter text.
2. If applicable, were there any changes to the supervisory agreement? Click or tap here to enter text.
(Please Attach Existing Supervisory Agreement)
3. How are individuals with more complex psychopharmacological needs identified and flagged by the psychiatric nurse practitioner for consultation or supervision with a psychiatrist? Click or tap here to enter text.
4. Have the required trainings been completed by the Psychiatrist Nurse Practitioner? Click or tap here to enter text.



1. <https://practiceinnovations.org/Learning-Community-Login>

Promoting Recovery Through a Mobile, Team-Based Approach
Engaging Consumers in Assertive Community Treatment
Unit 1: ACT Transition: The Road to Recovery
ACT Core Principles
Person-Centered Treatment Planning in Assertive Community Treatment
Person-Centered Treatment Planning (Version 2)
FIT Module 8: Motivational Interviewing
FIT Module 12: Stage-Wise Treatment
ACT: Introduction to Role: Prescriber
Supervision Guidelines
Recommended Prescriber Trainings

ACT Program Guidelines Waiver for Psychiatric Coverage Extension Request Form
To affirm ACT Team request and compliance with each requirement, check box in left column.

<input type="checkbox"/>	<p>My ACT Team is requesting <input type="checkbox"/> a continuation of requested coverage as indicated below:</p> <p style="padding-left: 40px;"><input type="checkbox"/> new coverage as indicated below:</p> <p><input type="checkbox"/> Option A: 0.48/0.68 FTE hours for Psychiatric coverage to be split between a Psychiatrist and a PNP –(at a minimum of 0.68 FTE for a 68 team and 0.48 FTE for a 48 team): Provide minimum hours to be covered by PNP: Click or tap here to enter text. Provide minimum hours to be covered by Psychiatrist: Click or tap here to enter text.</p> <p>OR</p> <p><input type="checkbox"/> Option B: 1.0 FTE psychiatric coverage provided by PNP, who will receive supervision from a Psychiatrist through a supervisory agreement/contract (see ACT Program Guideline Waiver Requirements).</p>
<input type="checkbox"/>	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.
<input type="checkbox"/>	Attached is the supervisory agreement for the PNP (ONLY needed for Option B).
<input type="checkbox"/>	Our ACT team has received sign off from provider leadership to submit this request. Please provide Name and Title of Executive Director: Click here to enter text.

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



For Field Office Use ONLY

Request Received: [Click or tap to enter a date.](#)

Additional information requested (with dates): [Click here to enter text.](#)

Date Sent to LGU/SPOA: [Click here to enter text.](#)

NYS OMH Field Office supports request: Yes No