New York State Office of Mental Health

PSYCKES

PSYCKES Provider Contact Form

Provider/Hospital
Name: _____
Address: _____

If provider is part of a larger system or network, please specify:
Name: _____
Address: _____

Chief Executive Officer or Executive Director
Name : _____
Title: _____
Address: _____
Telephone #: _____ Email Address: _____

Director of Utilization Review/Director of Quality Management
Name : _____
Title: _____
Address: _____
Telephone #: _____ Email Address: _____

PSYCKES Point Persons

Providers will need to develop policies and procedures for implementing PSYCKES, e.g. for staff training, obtaining and documenting client consent, and protecting health information. OMH strongly encourages providers to designate as PSYCKES Point Persons individuals with institutional expertise and leadership responsibilities aligned with this requirement.

Name : _____
Title: _____
Address: _____
Telephone #: Email Address:

Name : _____
Title: _____
Address: _____
Telephone #: _____ Email Address: _____

Please add additional contacts on a separate sheet, if needed.

This form was completed by
Name : _____
Title: _____
Telephone #: _____ Email Address: _____

Please return completed form to PSYCKES-Help
at PSYCKES-Help@omh.ny.gov or 212-740-7379 (fax).