NEW YORK STATE OF OPPORTUNITY. | Office of Mental Health

Reporting AOT County Transfer
Reissued: September, 2021

Chapter 1 of the Laws of 2013 extends Section 9.60 of Mental Hygiene Law to require that the director of an AOT program notify the DCS in the new county of residence when he or she has reason to believe that the assisted outpatient will change his or her residence during the pendency of an AOT Order. It is the responsibility of the DCS in the new county of residence to implement the AOT order.

To provide guidance on how the director of an AOT program can meet this requirement, OMH is issuing the below form which can be used to notify the Director of the County's/NYC's AOT Program. This form should also be sent tot he corresponding field office, when complete.

Name of Person Completing Form (include title and contact information):	
Date: Original Petitioner:	
Name of Individual on AOT: .	DOB: .
Dates of Current Order: .	☐ Initial ■ Renewal
County Initiating Transfer:	
AOT County Coordinator:	AOT County Coordinator Email:
Receiving County:	
Anticipated Move Date:	☐ Unknown
Reason for Move/Belief Client in Receiving County:	

Current Health Insurance: ☐Medicaid ☐ Medicare ☐No Insurance ☐Other-Please explain:	
Insurance ID:	
Income Source: ☐ SSI ☐ SSDI ☐ VA ☐ DSS ☐ Other-Please explain:	
Payee: ☐ Yes ☐ No	Payee Information:

Diagnosis:		
Current Medications:		
Scripts/refills: ☐ Yes ☐ No	Current medication supply:	
IM Medication: ☐ Yes ☐ No	Date last shot received:	Date next shot due:
Known Medical Conditions:		
Risk Factors/Violence Hx/Alerts:		

Care Manager:	Care Manager Contact Information:

☐ SPOA Application(s) sent to receiving county

☐ Copy of Current Order Sent/Attached to new county and appropriate NYS AOT Field Office(s)

Providers	Sending County	Receiving County
Care Coordination		
Clinic/Medication Management		
Housing		
Other		

Sending DCS/AOT Designee and County:

Name:

Signature:

Receiving DCS/AOT Designee and County:

Name:

Signature: