Adult Protective Services Legal Practice, Parts 1 & 2

2021 AATI Conference

Materials II

State Agency Directives

OCFS "Best Practices"

Mark E. Maves, Esq.,

Note- this compendium does not contain all State agency directives that pertain to APS, only those that are relevant to this presentation

Another note- for some reason MS WORD decided to re-start its page numbering at "2" beginning with 05-INF-010, so the Table of Contents looks weird. I tried to fix that, but clearly, I was not successful…

And yet another note- if you need a better copy to print of a particular once, all of the agency directives can be obtained from the OCFS website.

OCFS Policy Directives

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ADMINISTRATIVE DIRECTIVE

TRANSMITTAL: 90 ADM-40

DIVISION: Adult Services

TO: Commissioners of Social Services

DATE: October 25, 1990

SUBJECT: Protective Services for Adults: Client Characteristics

SUGGESTED DISTRIBUTION:	Directors of Services Adult Services Staff Medical Assistance Staff Income Maintenance Staff Agency Attorneys Staff Development Coordinators
CONTACT PERSON:	Kathleen Crowe, ext. 432-2996 Marsha Ross Meyers, ext. 432-2997 Janet Morrissey, ext. 432-2864 Irvin Abelman, ext. 432-2980 or (212) 804-1247
ATTACHMENTS:	Appendix A: State Health Department Grievance Resolution Mechanisms (available on-line)

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
83 ADM-15		Sec.403.3(a)	Article 9B	Bulletin	Sec.575.4(b)
85 ADM-5		Sec.505.14	Sec.460-c.7	194	NYCRR Title
88 ADM-23		Part 457	Article 9		14
89 ADM-22		Part 489	MHL		Sec.405.9(f)
		Sec.485.5(j)	Article 28		NYCRR Title
		Secs. 486.3 & 4	PHL		10

DSS-296EL (REV. 9/89)

I. PURPOSE

The purpose of this release is to provide additional clarification of the client characteristics for Protective Services for Adults (PSA) as set forth in Section 457.1(b) of the Department's regulations.

II. BACKGROUND

The client characteristics for Protective Services for Adults (PSA) set forth in Section 473 of the Social Services Law (SSL) have not changed since 1975 when the law was first enacted. These standards, which are the basis for determining PSA eligibility, are explained in more detail in Bulletin 194. Despite this, there continues to be varying interpretations of the client characteristics among the districts. This is especially true of the characteristic concerning the availability of other persons or agencies to provide assistance to an impaired adult who is otherwise eligible for PSA.

To clarify the client characteristics for PSA, Section 457.1(b) of the Department's regulations were revised effective December 23, 1986. This release further clarifies the PSA client characteristics and the criteria for PSA eligibility.

III. PROGRAM IMPLICATIONS

The following discussion of the PSA client characteristics will clarify the eligibility criteria for this service. This is expected to result in improved eligibility determinations by the districts and the achievement of greater statewide conformity in the delivery of this increasingly important service. Although this directive will affect PSA eligibility decisions in some districts, it will not require any district to change its organizational structure for the provision of PSA. Also, while we anticipate that this directive will result in the opening of additional PSA cases in some districts, we do not foresee a major fiscal impact since many of these cases would have been opened or maintained under other adult services categories. Therefore, this directive should assure that dependent adults served by the districts receive an appropriate level of service.

Section 457.1(b) of the Department's regulations defines PSA eligibility in terms of the following Client Characteristics:

Protective Services for Adults are provided to individuals 18 years of age and older who, because of mental or physical impairments:

are unable to meet their essential needs for food, shelter, clothing or medical care, secure entitlements due them or protect themselves from physical or mental injury, neglect, maltreatment or financial exploitation;

are in need of protection from actual or threatened harm, neglect or hazardous conditions caused by the action or inaction of either themselves or other individuals; and have no one available who is willing and able to assist them responsibly.

This means that any person 18 years or older who meets all of these client characteristics is eligible for PSA. The following discussion of the client characteristics will assist in enabling districts to achieve

consistency in making appropriate PSA eligibility determinations. A. PSA CLIENT CHARACTERISTIC #1:

because of mental or physical impairment are unable to meet their essential needs for food, shelter, clothing or medical care, secure entitlements due them or protect themselves from physical or mental injury, neglect, maltreatment or financial exploitation.

The adult must have a mental impairment and/or a physical illness or disability which renders him/her unable to obtain services necessary for his/her own care and protection. The disabling condition may either be temporary, intermittent or permanent. Conditions contributing to a client's disability may include, but are not limited to: mental illness; mental retardation; developmental disorders; Alzheimer's Disease and related disorders primarily associated with the elderly; acute physical illness; physical handicaps; and alcoholism and other forms of substance abuse.

There must be a causal relationship between the adult's impairment or disability and his/her failure to obtain necessary assistance. For example, an impaired adult who is refusing all services would be inappropriate for PSA if a determination is made by a qualified mental health professional that the adult is making a reasoned decision to refuse services, fully appreciates any potentially harmful consequences of this chosen course of action and the adult's reasons for refusing services have a sound basis in reality. Conversely, if an adult is refusing or interfering with the delivery of essential services, is not able to recognize the potentially harmful consequences of his/her action or inaction, is unable to offer reasons for his/her chosen course of action, or if the reasons given are inconsistent with the reality of the situation, PSA must be provided on an involuntary basis as set forth in 88 ADM-23.

If an involuntary client cannot be convinced to accept services on a voluntary basis, then the district must pursue an appropriate legal intervention as set forth in Section 457.6 of the Department's regulations or provide financial management services, such as representative or protective payee, as required by Sections 457.1(c)(9) and 457.5(c)(2) and (3) of the Department's regulations. Section 403.3(a) of the Department's regulations requires that adults be free to accept or reject services, except when involuntary legal actions or other involuntary protective interventions are pursued as part of a PSA services plan. Therefore, anytime a district pursues a legal intervention on behalf of a client as set forth in Section 457.6, the case must be opened as PSA. Financial management services not requiring court authorization, such as representative or protective payee, may be provided on a voluntary basis under other adult services categories, including Preventive and Residential Placement Services for Adults. However, financial management services provided on an involuntary basis must be provided under PSA.

B. PSA CLIENT CHARACTERISTIC #2

are in need of protection from actual or threatened harm, neglect or hazardous conditions caused by the action or inaction of either themselves or other individuals.

Evidence of one or more of the following risk factors must be present in order to satisfy this characteristic:

a. Failure of an impaired adult to receive adequate food, clothing, shelter or medical care, or to obtain those entitlements for which he/she is eligible;

b. Incidents of physical, verbal, mental or sexual abuse against an impaired adult by another person;

c. Incidents involving exploitation, theft or otherwise inappropriate use of an impaired adult's funds, property, possessions or services by another person or persons;

d. Incidents of suicidal or other life threatening or self-endangering behaviors;

e. Presence of a threat to the physical safety or health of an impaired adult as a result of dangerous or unsanitary conditions in the adult's home or physical environment;

f. Inability of an impaired adult to manage his/her personal finances in a manner that assures that his/her essential needs are met, or;

g. Failure of an impaired adult to obtain assistance with essential daily living activities which they are unable to perform themselves.

The above condition(s) may either be a result of the adult's own actions or inactions or the actions or inactions of other persons. C. PSA CLIENT CHARACTERISTIC #3:

have no one available who is willing and able to assist them responsibly.

This client characteristic is most subject to varying interpretations. There are wide differences in the commitment and capacity of family members and other involved individuals to meet the difficult demands of caring for dependent adults. This issue is further complicated by the fact that most relatives are not legally responsible for the care of their impaired adult family members. Furthermore, while other agencies have responsibilities for meeting the needs of dependent adults, the responsibilities of these agencies often have been unclear. These ambiguities have compounded the problem of determining an individual's eligibility for PSA. In order to clarify the precise intent of this client characteristic, the responsibilities of relatives and other service delivery systems are discussed in detail below.

1. Relatives and Friends

Districts are encouraged to maximize the involvement of family members and friends in the adult's plan of care. It must, however, be understood that if these individuals are either unwilling or incapable of acting in the best interest of the client in a reliable and responsible manner, then they cannot be considered as an available service resource. This is true even in the case of spouses who are financially responsible for the care of their husband or wife, but who may not be willing or capable of providing the necessary care and services. Therefore, in situations in which relatives or friends are involved in a client's care, the ability and intentions of each person involved with the client must be carefully assessed and documented in the case record.

In cases in which other individuals are available to assist, the district's decision to open or maintain the case as PSA must be based on the caseworker's assessment as to whether it can be reasonably assumed that the involvement of others will assure that the impaired adult's essential needs, including financial management, will be met in a responsible manner for the foreseeable future. If the assessment indicates that it cannot be reasonably assumed that family members and friends are willing and capable of meeting a client's essential needs and protecting the client from harm, a PSA case must be opened or maintained. As indicated above, financial management services which are provided to involuntary clients must be provided as part of a PSA services plan.

2. Hospitals

a. Patients Who Are Being Discharged To The Community.

State Health Department regulations (Title 10 NYCRR, Section 405.9(f)) require hospitals to develop discharge plans for all patients in need of post hospital care. Hospital discharge planning staff are required to assist the patient in obtaining any services that will be needed by the patient upon discharge. The discharge planning process must begin as soon as is practical following a patient's admission to a hospital. As stated in these regulations, the following conditions must be present before a patient may be discharged:

. the patient must be determined by a physician to be medically ready for discharge;

. the hospital must ensure that the patient has a discharge plan which meets the patient's post hospital needs;

. the hospital must ensure that all necessary post hospital services are in place or reasonably available to the patient; and

. the patient will be discharged to a safe environment.

PSA may be an essential component of a plan of care to maintain a dependent adult in the community upon discharge from a hospital. Accordingly, PSA staff should actively participate in the hospital discharge planning process at the earliest possible time for patients who will require PSA services upon discharge to the community. A PSA investigation shall be commenced

upon receipt of a referral involving a hospitalized adult if both of the following conditions are met:

- the hospital has provided information which leads the district to conclude that the patient will return to the community upon discharge and not be placed in a residential care facility; and

- there is evidence to indicate that the patient may be eligible for PSA upon returning to the community.

There may be little time between a hospital admission and clearance of a patient for discharge. For this reason, it is important for PSA staff to promptly respond to hospitals' referrals. To assure the appropriateness of these referrals, districts have a right to receive all pertinent information from the hospital regarding the patient's medical, psychiatric and social condition with each PSA referral. If this information is not provided by the hospital, the referral does not have to be accepted by the district unless information has been provided by other sources to support the referral. Once the necessary information is provided by the hospital to support a PSA referral, it must be responded to in accordance with Section 457.1(c)(2) of the Department's regulations and 85 ADM-5. If the client remains hospitalized, the initial visit to the client must be conducted in the hospital. If the subsequent PSA assessment determines that a hospitalized adult will be eligible for PSA upon the patient's discharge to the community, a PSA case must be opened.

The PSA assessment of a hospitalized adult should be conducted in close cooperation with hospital discharge planning staff. The PSA assessment should place special emphasis on the client's physical environment in the community and the degree to which the client's support systems will be able to meet the client's needs upon discharge. During the assessment period, PSA staff should initiate contacts with family members, friends and other agencies known to the adult to determine what contribution that they are willing and able to make to the client's care. It may be useful for PSA staff to conduct an on-site assessment of the client's living situation if there are questions about its suitability and safety or if there are indications of abusive or neglectful caregivers in the household. If no one else is present in the client's home, a home assessment may only be conducted with the client's permission and in the presence of a family member or other person who the client has given authority to enter the premises.

Nothing above pertaining to PSA assessments of adults in hospitals shall diminish the hospitals' primary responsibility for discharge planning set forth in Section 405.9(f) of State Health Department Regulations. This means that hospitals are ultimately responsible for accessing all necessary post hospital services, such as personal care and other home health services, prior to the patient's discharge. A hospital may not discharge a patient until all necessary services are in place. Discharge to PSA, in the absence of other necessary services, does not constitute an acceptable discharge plan. PSA does not assume primary case management responsibility until the patient is discharged from the hospital and has returned to the community.

In accordance with the aforementioned regulation, hospitals also are required to develop discharge plans for emergency room patients who require post hospital services. Therefore, districts must be prepared to respond to referrals made by hospital staff on behalf of persons who are about to be discharged from emergency rooms and appear to be in need of PSA. As stated above, districts have a right to receive all pertinent information on the person's medical, psychiatric and social condition with each PSA referral. Once the necessary information is available to support a PSA referral, it must be responded to in accordance with Section 457.1(c)(2) of the Department's regulations and 85 ADM-5.

b. PSA Clients Who Are Hospitalized.

If a client who is currently in receipt of PSA in the community is hospitalized and a decision is made to place the client in a certified residential care facility, including a psychiatric facility or a developmental center, the case must be maintained as PSA until the client's condition is stabilized and the placement plan is in place. If the district decides to close the case and is acting as a representative payee, the district must notify the appropriate local Social Security Office, or other appointing authority, that the client will enter a residential facility and the district will no longer serve as the client's payee. If the district was appointed as the client's conservator or committee, a PSA case must be maintained until the court relieves the district of this responsibility. If there is a plan for a hospitalized PSA client to return to the community, the case must be maintained as PSA throughout the period of hospitalization if the client does not otherwise become ineligible for PSA. In these situations, PSA must be part of the plan to discharge the patient to the community.

c. Hospitalized PSA Clients Requiring an Involuntary Legal Intervention.

As indicated in subsections a and b above, PSA must be involved in the development of community discharge plans for certain hospitalized adults. If a legal intervention is required on behalf of a hospitalized adult who is eligible for PSA as set forth above in subsections a and b and no other source of legal assistance is available, the district must pursue an appropriate legal intervention as set forth in Section 457.6 of the Department's regulations. However, if a hospitalized PSA client who is incapable of giving informed consent requires emergency or certain nonemergency medical treatment, it should be provided by the hospital under the auspices of Sections 2504 and 2805-d of the Public Health Law. These statutes give hospitals specific authority to provide emergency and certain non-emergency medical treatment on behalf of patients unable to give informed consent.

Districts should also be aware that hospitals have the authority to initiate other legal interventions on behalf of patients, including petitioning a court for a conservator or committee. Therefore, if a hospital pursues legal intervention which the district believes is in the best interest of a PSA client, the district is expected to cooperate and provide whatever assistance is necessary.

d. Patient Decision Making.

It is important to note that hospital patients have a right to self determination in choosing a discharge plan. This means that a patient who is insisting on returning to a dangerous home environment upon discharge is free do so unless it is determined that the patient lacks the capacity to make and understand decisions related to his or her care. Some seriously ill patients may simply leave the hospital against medical advice.

These situations can create complex and difficult problems for hospitals and PSA programs which require immediate and decisive action. Therefore, if a patient is choosing a course of action which will place him/her at risk of harm and there is any doubt about the patient's mental capacity, the district should strongly encourage the hospital to obtain a psychiatric evaluation prior to the individual's discharge. The psychiatric examination should focus specifically on the patient's present ability to make care related decisions, namely: o is the patient able to make and express choices about his/her decisions? o is the patient able to provide reasons for these choices?

o do the patient's reasons for choosing this course of action have a basis in fact and reality? and

o is the patient able to understand and appreciate the potentially harmful consequences of his/her chosen course of action?

If a determination is made that a patient is not presently capable of making care related decisions and the patient will be at risk of harm upon discharge, the hospital must act to prevent or to delay the discharge in accordance with applicable law and regulation. For those patients who are determined to have decision-making capacity, the hospital has no choice but to allow the patient to return to the community.

e. Payment To Hospitals for the Provision of Emergency Room and Board for PSA Clients Once Their Medical Needs Have Been Met.

Situations may occur in which hospitalized PSA clients are medically cleared for discharge because their medical needs have been met, but the client would be at risk of serious harm if discharged to the community at that time. The potential risk to the client may be the result of unsafe conditions in the client's home or due to the presence of abusive persons in the household. In these circumstances, and after all medical reimbursement for hospital care has been exhausted, districts may reimburse hospitals for the cost of emergency room and board for a PSA client in accordance with Section 457.1(c)(5) of the Department's regulations until a safe discharge can be arranged. Under the emergency room and board provision, districts may pay for room and board in hospitals for a maximum 30 days and only as an "integral and subordinate" part of a PSA plan. Districts are encouraged to negotiate rates with hospitals for the cost of room and board which do not exceed the alternate care rate for persons who are awaiting placement in a nursing home. During the period that the hospital is being paid under the emergency room and board provisions, the district must take the necessary actions, as part of a PSA plan, to assure a safe and habitable home environment for the client.

Districts may also use the PSA emergency room and board provisions to pay for hospital admissions under the following conditions:

o the individual can no longer be maintained in the community through the provision of other supportive services, and other payment sources such as Medicaid or Medicare are not available;

o the individual is determined to be eligible for PSA in accordance with Section 473 of the Social Services Law, Section 457.1(b) of the Department's regulations and the provisions of this directive;

o the care provided by the hospital must be an integral but subordinate part of a PSA services plan;

o no other appropriate temporary or permanent placement option exists at the time of admission;

o the payment rate for these admissions cannot exceed the Medicaid alternate care rate; and o payment for these hospital stays cannot exceed 30 days.

f. Health Department Grievance Resolution Mechanisms.

The State Health Department administers two programs to which hospital patients and their representatives can turn if they believe the patient is being prematurely or otherwise inappropriately discharged. The Discharge Review Program allows patients and their representatives to appeal and have an independent third party review their planned discharge. The State Health Department also operates a statewide hospital complaint investigation program. As indicated in Section IV.E of this directive, local district PSA staff are required to utilize these programs if, in their judgment, a PSA client who is incapable of making decisions about his/her care, as discussed above in subsection d, is being discharged inappropriately or prematurely, or if needed services are not in place in the community. These programs are discussed in greater detail in Appendix A of this document.

3. Community Support Services (CSS) and Intensive Case Management (ICM) Recipients

Section 575.4(b) of the Office of Mental Health's regulations defines Community Support Services (CSS) programs as follows:

"those clinical, social, rehabilitative, related administrative and other mental health and support services which are provided within the community and which enhance community living skills while preventing the unnecessary hospitalization of the seriously and chronically mentally ill individual who is determined to be eligible for such services...."

CSS providers are required to provide case management and an array of other appropriate services to their clients. The Office of Mental Health's Intensive Case Management (ICM) program is a Medicaid funded service which is responsible for providing enhanced services to certain mentally ill

adults with a history of frequent hospitalizations in order to maintain these individuals in the community and out of psychiatric institutions as long as possible. As a general rule, CSS and ICM recipients are not eligible for PSA because another agency, namely the CSS or ICM provider, is responsible for assuring the provision of case management and other apporpriate services which are necessary to meet the recipients' basic daily needs.

Because of the responsibilities of these programs, districts are not required to provide financial management services to a CSS or ICM recipient unless:

o the district is providing financial management services to the client, which include acting as his/her representative payee, as part of a PSA or other adult services plan at the time the client is determined to be eligible for CSS or ICM, in which case the district must continue to provide these services; or

o the district determines that a CSS or ICM recipient has other basic needs which these providers cannot address, such as the need for legal intervention, and the recipient is otherwise eligible for PSA.

Districts also may provide financial management services to other CSS and ICM recipients under other Title XX adult services categories, including Preventive and Residential Placement Services for Adults. It is important to note that these services can be provided only to eligible adults who accept them on a voluntary basis.

With the exception of arranging for involuntary admissions to psychiatric facilities pursuant to Article 9 of the Mental Hygiene Law, CSS and ICM programs are not required to pursue legal interventions on behalf of their recipients, such as petitioning the court to obtain a conservator or a committee. Consequently, if a CSS or ICM program is unable to locate anyone else to pursue an appropriate legal intervention on behalf of one of their clients, it is the responsibility of the district to assess the situation and, if determined necessary, pursue an appropriate legal intervention in accordance with section 457.6 of the Department's regulations. It is expected that CSS and ICM staff will cooperate with, and provide pertinent information to district staff to enable them to assess the situation and to pursue appropriate legal interventions when necessary on behalf of CSS and ICM clients. Once a district determines that it is appropriate to pursue a legal intervention on behalf of a CSS or ICM client, a PSA case must be opened and services provided in accordance with Part 457 of the Department's regulations. However, if a CSS or ICM recipient requires an involuntary admission to a psychiatric facility, the CSS or ICM provider should take the appropriate steps to obtain an involuntary admission in accordance with the provisions of Article 9 of the Mental Hygiene Law. 4. Persons Served by Other Community Agencies

The legal responsibility of other community agencies for the care and protection for individual clients is limited. As with family members, the district's decision to provide PSA to a person served by another agency must be based on a determination as to whether or not the involvement of the other agency(ies) assures that all of the essential needs of the adult,

including financial management, are met and that the client is protected from harm. If the answer to this question is no, then PSA must be provided.

In many situations, community agencies will not serve involuntary clients. Although some community based agencies may be authorized to apply for, and to provide various types of guardianship services, such as conservator or committee, and to provide financial management services, generally they are not required to do so. If a client who is being served by a community agency is refusing services, the community agency, with the assistance of the district if necessary, should make all possible efforts to convince the client to accept services on a voluntary basis. If the client continues to refuse to accept services and requires an involuntary intervention, the district must be prepared to pursue an appropriate intervention in accordance with Section 457.6 of the Department's regulations or apply to act as a representative or protective payee as set forth in Sections 457.1(c)(9) and 457.5(c)(2) and (3) of the regulations.

5. Recipients of Home Care Services

Home care recipients with decreased mental capacity who are without family or other supports are especially vulnerable to neglect, exploitation and abuse. Because of the vulnerability of these clients, Section 505.14(a)(4)(ii) of the Department's regulations requires districts to assume responsibility for the supervision and direction of Personal Care Services recipients who are determined to be "incapable of self direction" and who have no one else to assume responsibility for their care. Self direction is defined as the capacity for "making choices about his/her activities of daily living, understanding the impact of these choices and assuming responsibility for the results of the choice".

For non-self directing clients, as defined above, PSA must assume primary responsibility for assuring that their needs are met. This standard must also be used for adult recipients of: Title XX homemaker services and housekeeper/ chore services, Certified Home Health Agency (CHHA) services and Long Term Home Health Care (LTHHC) programs. For clients in need of PSA who are receiving home care through the State Office for the Aging's Expanded in Home Services for the Elderly Program (EISEP), services should be provided in accordance with 86 INF-32.

PSA clients can become stabilized once they are in receipt of Home Care Services as part of a PSA plan. In certain circumstances, PSA services may no longer be needed and primary case management responsibility can be assumed by the Home Care Services program. Under the following conditions, districts may transfer cases and primary case management responsibility from PSA to the appropriate Home Care Program.

(a.) A self-directing PSA client agrees to accept the provision of necessary home care services in accordance with a care plan and is in receipt of sufficient home care services to address any risk of serious harm which is associated with the client's need for such services.

(b.) A non self-directing PSA client is in receipt of home care on a voluntary basis, has a responsible family member or other person who has

actively assumed responsibility for direction of the client's plan of care and the client is in receipt of sufficient home care services to address any risk of serious harm which is associated with the client's need for such services.

(c.) A non self-directing PSA client has another person or agency not under contract to the district to provide PSA who has been appointed as the client's conservator, committee or guardian and the client is in receipt of sufficient home care services to address any risk of serious harm which is associated with the client's need for such services.

In the absence of the above conditions, PSA must maintain primary case management responsibility for joint PSA-Home Care Services cases.

6. Persons Residing in Long Term Residential Care Facilities Certified by State Agencies

Adult residents of long term residential care facilities certified by State agencies are generally not eligible for PSA. Long term residential care facilities are responsible for meeting the essential needs of their residents and for providing a safe environment in accordance with applicable laws and regulations.

However, there are situations in which certain persons residing in long term care facilities are eligible for PSA. The specific situations in which persons residing in long term residential care facilities are eligible for PSA are discussed below.

a. Residents of Facilities Certified by the Department of Health (Skilled Nursing Facilities and Health Related Facilities) and Residential Care Programs Certified by the Office of Mental Health (OMH) and the Office of Mental Retardation and Developmental Disabilities (OMRDD).

If a client who is currently in receipt of PSA in the community is placed by PSA into one of the above mentioned facilities, the case must be maintained as PSA until the client's situation has been stabilized. If, in such a case, the district is acting as a conservator, committee, or guardian, the district must continue to act in this capacity until the court relieves the district of this responsibility. Once the district is relieved of this responsibility, the PSA case may be closed. If the district decides to close the case and is acting as representative payee, the district must notify the local Social Security Office, or other appointing authority, that the district will no longer act in this capacity and the PSA case may be closed.

Occasionally, residents of these facilities will be discharged to the community or will return to the community against medical advice and be in need of PSA. Where a district receives a PSA referral, as defined in Section 457.1(c)(2) of the Department's regulations, from one of the aforementioned facilities concerning a client who is about to be discharged to the community, a PSA assessment must be completed in accordance with Section 457.2(b) of these regulations. If it is determined that the client will be eligible for PSA upon discharge, a PSA case must be opened. A facility may not discharge a patient until all necessary services are in

place. Discharge to PSA, in the absence of other necessary services, does not constitute an acceptable discharge plan. PSA does not assume primary case management responsibility until the patient is discharged from the facility and has returned to the community.

There may be other situations in which a person in a facility certified by another state agency is in need of services other than protective services from a district. In these situations, services shall be provided under Residential Placement Services for Adults as set forth in 89ADM-22.

b. Persons Residing in Adult Care Facilities Certified by the Department, with the exception of Family-type Homes for Adults and Shelters (Adult Homes, Residences for Adults and Enriched Housing Programs).

Local districts have the same responsibilities to provide PSA to persons who are residing in adult homes, residences for adults and enriched housing programs as they do for persons in facilities certified by other state agencies as described above in Subsection 6a. Another situation in which a resident of one of the aforementioned Adult Care Facilities could be in need of PSA involves the closing of a facility. Although Section 485.5(j) of the Department's regulations requires operators of Adult Care Facilities to submit a plan for the closure of their facility to the appropriate regional office of the Division of Adult Services and to assist the residents in arranging for appropriate placements, there are situations in which the involvement of the district is necessary and appropriate. In these situations it may be necessary for the local district, in conjunction with staff from the appropriate regional office of DAS, to assist in assessing the needs of residents and arranging for appropriate placements. In most of these situations services would be provided by the districts under Residential Placement Services for Adults in accordance with 89 ADM-22.

However, in some situations a resident of a facility which is about to close may refuse services and have a diminished capacity to make decisions about his/her care. In these situations, if there is no one else willing and able to assist the resident in a responsible manner, PSA must be provided, including the use of appropriate legal interventions as set forth in Section 457.6 of the Department's regulations.

There may be other situations in which a person residing in one of the aforementioned adult care facilities may be in need of services from a district. These services may be provided under Residential Placement services for Adults as set forth in 89 ADM-22. However, if a district is providing financial management services to residents in these facilities, these services must be provided under PSA if the client does not voluntarily accept these services.

c. Persons Residing in Family-type Homes for Adults.

In accordance with the provisions of Section 460-c.7 SSL and Part 489 of the Department's regulations, local districts, under the supervision of the Department, are responsible for the inspection and supervision of Family type Homes for Adults. Generally, the service needs of Family- type Home for Adults residents can be met under Residential Placement Services for Adults as set forth in 89ADM-22. However, there may be situations involving

Family-type Home residents which are beyond the scope and ability of the operator to address. In these situations it may be necessary to provide PSA to a Family-type Home resident.

Situations may occur in which a resident of a Family-type Home for Adults is at risk of serious harm or his/her property is endangered and there is no one available to assist the resident in a responsible manner. Specific examples may include residents who require medical or psychiatric treatment or a higher level of care, or residents who are victims of abuse or exploitation by family members or others outside of the home. In these situations, if a resident refuses to accept services, including a placement in a more appropriate level of care, and exhibits a diminished capacity to make decisions regarding his/her own care, a PSA assessment must be completed. If the resident continues to refuse services or placement and is determined to be incapable of making decisions on his/her own behalf, PSA must pursue an appropriate legal intervention in accordance with Section 457.6 of the Department's regulations even if the operator, family members or friends object to this course of action.

There may be other situations in which a Family-type Home resident requires financial management services which do not require a legal intervention, such as representative and protective payee. Although a Family-type home operator may provide financial management services to a resident, the district must assume this responsibility if the operator in unwilling or unable to provide these services and if there are no other responsible persons willing to act in this capacity. In those situations in which a district must provide financial management services on behalf of a Family type Home resident, these services must be provided under PSA if the client refuses to accept services. If the client accepts these services voluntarily, they should be provided under Residential Placement Services for Adults. Finally, when a Family-type Home is closing, it may be necessary for a district to provide PSA to those individuals for whom a legal intervention is required to secure an appropriate placement.

d. Uncertified Adult Care Facilities.

Sections 486.3 and 486.4 of the Department's regulations set forth provisions concerning the Department's inspection and enforcement responsibilities over uncertified adult care facilities. Section 486.3 gives the Department the authority to inspect any facility which reasonably appears to be operating as an adult care facility. This means that any facility which provides personal care and/or supervision to its residents or any facility whose residents require personal care and/or supervision is subject to inspection by the Department.. Any information pertaining to uncertified adult care facilities must be reported to the appropriate Regional Office of the Division of Adult Services.

Regional office staff of the Division of Adult Services are responsible for the investigation of uncertified facilities caring for five or more residents and for the commencement of appropriate enforcement action. In accordance with the provisions of 89 ADM-22, local districts, in close cooperation with the appropriate regional office of the Division of Adult Services, are responsible for investigating uncertified adult care

facilities serving four or fewer residents. In uncertified facilities serving four or fewer residents, districts are responsible for assessing the services needs of all residents and for relocating residents, when necessary. As discussed in 89 ADM-22, in certain situations in which the health, welfare or safety of a resident of an uncertified adult care facility serving four or fewer adults is threatened, or an impaired resident in one of these facilities refuses an appropriate placement, a PSA assessment must be completed by the district. If the assessment indicates that the person is incapable of making decisions regarding his/her care, a PSA case must be opened and appropriate services provided, including the pursuit of necessary legal interventions as specified in Section 457.6 of the Department's regulations. In these situations, the district must pursue the necessary legal intervention to provide or arrange for the provision of services to protect the individual, including arranging for a placement in an appropriate facility, even if the operator, family members or friends oppose this course of action.

The only exception to this policy involves uncertified skilled nursing facilities (SNFs) serving three or fewer individuals or uncertified health related facilities (HRFs) serving six or fewer individuals. Because the State Department of Health does not require SNFs or HRFs of these sizes to be certified, they are operating legally as long as they are not caring for persons who require another level of care, such as adult home or family-type care. Therefore, in situations involving persons in need of SNF or HRF care who are; residing in these facilities, refusing services and unable to make decisions on their own behalf, PSA should not pursue a legal intervention to arrange for an appropriate placement unless there are specific conditions which endanger the health, welfare or safety of the residents. In situations involving uncertified facilities of this size which are serving a mixed population, the appropriate legal intervention must be pursued by PSA on behalf of those residents who refuse placement, are unable to make decisions and do not require SNF or HRF care regardless of whether or not the operator, family members of friends support this course of action. A legal intervention to arrange for an appropriate placement for a resident of a mixed facility who requires SNF or HRF care should only be pursued if conditions exist which threaten his/her health, welfare and safety.

Local district staff may also be called upon to assist regional office staff in the assessment of the services' needs of persons living in uncertified adult care facilities serving five or more adults. Regional office staff may also require assistance from the districts in relocating individual residents if it is determined that the needs of the residents are not being met. If a resident refuses to accept services and it is determined that the person is incapable of making decisions concerning his/her own care, a PSA case must be opened and an appropriate legal intervention must be pursued in accordance with Section 457.6 of the Department's regulations. As stated above, the district must pursue the appropriate legal intervention to provide necessary services, including placement in a certified facility, even if this course of action is opposed by the operator, family members or friends. Services to residents of uncertified facilities who do not meet the PSA criteria should be provided under Residential Placement Services for Adults as set forth in 89 ADM-22.

e. Shelters

Adult shelters and family shelters which are certified or approved by the Department are required to monitor individual residents, to identify the need for medical or psychiatric treatment and other services, including arranging for medical and psychiatric evaluations, and to provide other appropriate services. In the event that a shelter resident requires medical or psychiatric treatment, placement in a facility providing a higher level of care, or other services, shelter staff are required to provide or arrange for necessary services, including a transfer to an appropriate medical, psychiatric or residential care facility.

Situations occur in which residents who are placing themselves or other residents in danger must be involuntarily transferred or discharged from a shelter. If a shelter resident who is being involuntarily discharged or transferred appears to be mentally ill and at risk of serious harm, shelter staff should initially contact mental health officials or the police to attempt to have the shelter resident transported and hospitalized in accordance with the provisions of Article 9 of the Mental Hygiene Law. If a judgmentally impaired adult resident who is facing involuntary discharge or transfer from a shelter requires a higher level of care, or is otherwise at risk of serious harm, and all other efforts to resolve the situation have been unsuccessful, and if no other person or agency is willing and able to assume responsibility for the protection of the resident, a PSA referral would be appropriate and a PSA assessment must be conducted. If a PSA assessment determines that a resident facing involuntary termination or discharge from a shelter is eligible for PSA, a PSA case must be opened by the district and appropriate legal intervention must be initiated in accordance with Section 457.6 of the Department's regulations.

To summarize, in situations where there are relatives, friends or other agencies involved in a case, the district's decision to open or maintain the case as PSA should be based on whether the services provided by the other parties assure that all essential needs are met and there is no risk of harm to the adult. If the answer to this question is no, the case must be opened or maintained as PSA.

IV. REQUIRED ACTION

A. Local district PSA intake staff shall be advised of the PSA eligibility criteria which are set forth in this directive. For referrals received on or after January 1, 1991, the aforementioned criteria must be used in screening PSA referrals and in determining PSA eligibility.

B. For cases opened prior to January 1, 1991, at the next scheduled recertification, all PSA, Preventive Services for Adults, Residential Placement Services for Adults, Homemaker, Housekeeper/Chore and other adult services cases must be reviewed against the PSA eligibility criteria set forth in this directive. Cases which meet the PSA criteria discussed above must be opened or maintained as PSA. Cases which do not meet the PSA criteria shall be served under another appropriate Title XX service category or closed, if appropriate. This review must be completed by June 30, 1991.

C. Each district shall notify all public and private hospitals which serve the district, or organizations representing the hospitals, of the PSA eligibility criteria for patients in hospitals as set forth in Section III.C.2. above. This notification should be addressed to hospital administrators, discharge planning coordinators and/or directors of social work.

D. Districts shall initiate efforts to establish written agreements with local hospitals or organizations representing the hospitals. At a minimum these agreements must delineate the responsibilities of local district PSA units and hospitals for patients meeting the PSA eligibility criteria upon discharge as set forth in Section III. C.2. above. These agreements shall contain a conflict resolution process. Districts must make documented efforts to have written agreements in place with all local hospitals and/or organizations representing the hospitals no later than June 30, 1991.

E. Local district PSA staff shall submit formal complaints to the Hospital Discharge Review or Complaint Investigation Programs discussed in Section III.C.2.f of this directive and in Appendix A in the situations described below.

1. A formal complaint must be registered with the Hospital Discharge Review Program on behalf of a hospitalized PSA client who is incapable of making decisions about his/her care if, in the judgement of PSA staff:

o the patient is not medically ready to leave the hospital and the hospital is refusing to postpone a discharge; or

o the hospital has not established an acceptable discharge plan to meet the patient's post hospital needs and the hospital refuses to correct this problem; or

o needed post hospital services have not been secured or will not be reasonably available to the patient upon the patient's discharge to the community and the hospital refuses to correct the problem.

2. A formal complaint must be registered with the Hospital Complaint Investigation Program on behalf of a hospitalized PSA client who is incapable of making decisions about his/her care if, in the judgement of PSA: o the patient or PSA was not given the right to appeal a discharge; or o the patient was prematurely discharged from the hospital.

F. Each district shall establish a written linkage procedure between itsPSA and Personal Care Services programs. This procedure must contain a process for assuring that appropriate Personal Care Services cases are carried as PSA in accordance with the criteria set forth in Section III. C.5. For districts with separate units handling PSA and Personal Care cases, the procedure must contain a process for determining ongoing case management responsibility for cases receiving Personal Care Services which is consistent with the criteria set forth in Section III. C.5. Districts must have a PSA Personal Care Services linkage procedure in place by June 30, 1991. Districts should also initiate efforts to establish

written linkage procedures between its PSA program and other Home Care Services providers as part of its continuing efforts to enhance interagency cooperation pursuant to Section 473.2(a) of the Social Services Law and Section 457.7 of the Department's regulations.

G. Action must be taken to assure that other units of the local district, including Income Maintenance, Medical Assistance and Legal are advised about the PSA eligibility criteria as described in this directive. If necessary, appropriate revisions shall be made in the intra-agency referral procedures of the district.

H. As part of their mandated public education and outreach efforts as set forth in Section 457.7 of the Department's regulations, local district staff must advise other agencies about the PSA eligibility criteria discussed above, including agencies representing the following service areas: aging, health, mental health, legal and law enforcement. V. SYSTEMS IMPLICATIONS

None

VI. EFFECTIVE DATE

January 1, 1991

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Judith Berek
Deputy Commissioner
Division of Adult Services

APPENDIX A: State Health Department Grievance Resolution Mechanisms

The New York State Health Department administers two programs to which hospital patients and their representatives can turn if they believe the patient is being prematurely or otherwise inappropriately discharged. These programs are discussed below. I. Discharge Review Program

Effective January 1, 1988, Article 28 of Public Health Law was amended to allow hospitalized patients to appeal and have an independent third party review their planned discharge. (Components of this program are not applicable to Medicare patients who are covered under a Federal review system.) The Discharge Review legislation requires hospitals to provide patients with an "Admission Notice" that explains the patients' rights and a "Discharge Notice" which must be given to the patient 24 hours before the patient's anticipated discharge from the hospital. During this 24 hour period, the patient may request a review of the discharge for one of the following reasons:

1. the patient believes that he/she is not medically ready to leave the hospital;

2. the patient believes that the hospital has not established an acceptable discharge plan for his/her post-hospital needs; or

3. the patient believes that needed post-hospital services are not secured or reasonably available.

If the patient decides to appeal a discharge, an independent review agent approved by the State Health Department will review the patient's medical records, speak with the patient's physician and discuss the case with the patient or the patient's representative. During the review period, the patient can remain in the hospital. If the review agent agrees with the patient, continued hospitalization must be provided to the patient.

For Medicaid Patients, an appeal can be made to or further information can be obtained from the State's Medicaid independent review agent at (718) 8967320.

Although Medicare patients are not covered by the State's Discharge Review Program, they may appeal to the Medicare Peer Review Organization (PRO) for New York State at (516) 437-8134.

Independent discharge review programs are also available for patients who are covered by Blue Cross, commercial insurance or other payment mechanisms. Information on the specific program designated for each hospital can be obtained from the hospital discharge planning coordinator.

Additional information can be obtained on the discharge review program from the State Health Department at (518) 473-7758.

II. Hospital Complaint Investigation Program

The State Health Department also operates a hospital complaint investigation program through its Area Offices. Patient complaints are investigated and, where necessary, hospitals are required to take corrective action. If patients believe that they were not given their right to appeal a discharge or were discharged prematurely, they or their representative can call the Health Department directly to register a complaint.

Below is a list of phone numbers of the State Health Department's Area Offices and the name of the Hospital Program Director in each office.

Albany Area Office
Mary Ann Tosh
Hospital Program Director
(518) 457-4853

Buffalo Area Office
Robert Braun
Hospital Program Director
(716) 847-4357

Rochester Area Office
Sherry Emrich
Hospital Program Director
(716) 423-8048

Syracuse Area Office
Jessica DeMarzo
Hospital Program Director
(315) 475-7514

New Rochelle Area Office
Susan Berry
Hospital Program Director
(914) 632-3547

New York City Area Office
Carlos Perez
Deputy Area Administrator
(212) 502-0833

ADMINISTRATIVE DIRECTIVE

TRANSMITTAL: 96 ADM-18

DIVISION: Services & Community Development

TO: Commissioners of Social Services

DATE: October 3, 1996

SUBJECT: Protective Services for Adults: Revised Process Standards

SUGGESTED DISTRIBUTION:
- Directors of Services
- Adult Services Staff
- County and Agency Attorneys
- Staff Development Coordinators

CONTACT PERSON: Any questions concerning this release should be directed to the district's Adult Services Representative as follows:
- Kathleen Crowe, (518) 432-2985 or User ID ROF017
- Carole Fox, (518) 432-2864 or User ID AX5050
- Michael Monahan, (518) 432-2667 or User ID AY3860

ATTACHMENTS: Revisions to Part 457 of the Department's Regulations (Not available on line)

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
89 ADM-22	94 ADM-4	457	Article 9-B		96 LCM-49
94 ADM-4					DSS-3602A
93 ADM-23					DSS-3602B
95 INF-38					DSS-3602C
					DSS-3603

DSS-296EL (REV. 9/89)

I. PURPOSE

The purpose of this directive is to advise social services districts of the revised Process Standards for the Protective Services for Adults (PSA) Program. The revised standards apply to all PSA case activity on or after May 31, 1996.

II. BACKGROUND

The original PSA Process Standards were developed by the Department in collaboration with a committee of social services district representatives and became effective on April 1, 1985. The Process Standards were revised in 1991 and again in 1994 as a result of revisions to Part 457 of the Department's regulations. The Process Standards are again being revised to reflect amendments to Part 457 of the Department's regulations, which became effective on May 31, 1996. As indicated in 96 LCM-49, copies of the revised regulations were sent to social services districts on April 12, 1996.

III. PROGRAM IMPLICATIONS

The revised PSA regulations and the provisions of this directive provide easements to the social services districts in the following areas:

° The maximum time frame for the completion of a PSA assessment/services plan has been increased from 30 to 60 days after the date a referral is received.

° Services plan updates are now required six calendar months following the referral date and every six calendar months thereafter. Previously, services plan updates were required four and seven calendar months following the referral date and every six months thereafter.

° For some PSA clients living in the community, the minimum frequency of home visits has been reduced from at least once every calendar month to at least once every three calendar months with face to face client contact required in the calendar months in which home visits are not made. A home visit at least once every calendar month continues to be required for PSA clients under the following circumstances:

1. when abuse, neglect or exploitation by another person is suspected or documented; or

2. when environmental conditions exist in the home which are a threat to the health and safety of the client; or

3. when a client is homebound or when there is no other way to have face to face contact with the client without making a home visit.

° Requirements for visits to PSA clients who are permanent residents of residential care facilities, including Family Type Homes for Adults, have been eliminated. The required frequency for telephone contact with residential care facilities to monitor the condition of PSA clients has been reduced from at least monthly to at least once every three months.

° The requirement that districts have written procedures, subject to Department approval, for the provision of services to involuntary clients has been eliminated. IV. REQUIRED ACTION

A. Response to Referrals

Section 457.1(c)(2) of the Department's regulations requires a prompt response and investigation of PSA referrals. Districts must commence an investigation as soon as possible , but not later than 24 hours, after receipt of a PSA referral when it is determined that a life threatening situation exists. If a life threatening situation does not exist, an investigation must be commenced within 72 hours of the referral and a visit must be made to the client within three working days of the referral.

A PSA referral is defined in the regulations as any written or verbal information provided to a district in which a specific person is identified as apparently in need of PSA, or any verbal or written information provided to a district on behalf of an adult for whom the district determines that a PSA investigation and assessment is necessary.

It is the district's responsibility to determine whether a life threatening situation exists at the time the referral is made. If district staff cannot determine whether a life threatening situation exists at time of the referral, the situation must be treated as life threatening and immediate action must be taken.

For more detailed information on responding to referrals, including the use of the DSS-3602A (PSA Intake Disposition), please consult 93 ADM-23, "Protective Services for Adults: Intake".

B. PSA Assessment/Services Plan

Section 457.2(b)(4) of the Department's regulations requires the completion of a PSA Assessment/Services Plan (DSS-3602B) for each PSA client. The PSA Assessment/Services Plan must be completed and signed within 60 days of the date of referral. For PSA cases which will not receive service beyond the assessment period, districts have the option of completing the DSS-3602C (Determination of PSA Ineligibility) in lieu of the DSS-3602B. This form also must be completed within 60 days of the date of referral. The date of completion is determined by the date of the supervisor's signature on these forms. Please consult 93 ADM-23 for more information on the completion of these forms.

The increase in the assessment period, from a maximum of 30 to 60 days, places greater responsibility on PSA caseworkers and supervisors to promptly identify and address emergent client needs during the assessment period. As stated in Section 457.(2)(b)(4)(ii) of the Department's regulations, the services needs of individuals who are being assessed for PSA must be addressed promptly and approriately regardless of the date the PSA assessment/services plan is completed. Accordingly, potential health risks, environmental hazards or suspected acts of abuse, financial exploitation and neglect of clients by other persons must be promptly and aggressively investigated and addressed. Decisive action also must be taken during the assessment period to promptly address unmet basic client needs for food, clothing, shelter, medical treatment and homecare. C. PSA Assessment/Services Plan Review/Update

In accordance with the revisions to Section 457.2(b)(5) of the Department's regulations, the PSA Assessment/Services Plan Update (DSS-3603) must be reviewed and updated as often as necessary to ensure that the services provided continue to be necessary and appropriate, but, at a minimum, within six calendar months from the date of referral and every six calendar months thereafter. The date of completion of the PSA Assessment/Services Plan Review/Update is determined by the date of the supervisor's signature. In addition, a DSS-3603 must be completed when a PSA case is transferred or closed, except when a closing is due to a client's death. For more information on the completion of the DSS 3603, please consult 93 ADM-23.

D. Progress Notes

Section 457.2(c) of the regulations requires that progress notes be maintained as part of the client record as prescribed by the Department. Requirements for the completion of PSA progress notes are discussed below.

1. Definition

Progress notes are concise case record entries which provide a chronological overview of important activities and events regarding a PSA case. The activities and events recorded in the progress notes should provide an up-to-date description of activities undertaken by the caseworker to complete the client's assessment, service plan and subsequent reviews. They should include any other pertinent information concerning a case which is not recorded elsewhere or which is referred to in the record but needs to be expanded upon. 2. Recording, Content and Utilization

a. Progress notes begin at the time a PSA referral is received. Progress notes must be recorded as soon as possible, but within 30 days of the occurrence of the event or receipt of the information which is to be recorded. Progress notes may be handwritten or typed; however, handwritten notes must be

legible to anyone reading the case record. Progress notes must include the date of the event, the date the entry was made, and the name or initials of the person making the entry. Examples of the type of information to be recorded include but are not limited to:

(1) information obtained at the time of referral;
(2) information concerning the provision of emergency services if appropriate;
(3) activities related to collecting information from other agencies and individuals which is needed to formulate the PSA Assessment/Services Plan and subsequent reviews;
(4) action taken to implement the Service Plan;
(5) contacts with the client;
(6) contacts with other agencies or divisions/units of the local social services district;
(7) contacts with other collaterals (e.g. relatives, friends, neighbors, landlord); and (8) significant events which result in new service needs or affect service provision.

b. Since progress notes may be used to support legal proceedings to secure protective services, progress notes should be factual and void of ambiguous or opinionated statements, unless clearly stated that the information is opinion. Progress notes made following contacts with the client must include the caseworker's observations regarding the client's mental and physical condition; a description of the client's social and environmental setting and his/her ability to function in that setting; any specific behaviors which may indicate a need for PSA; and the client's attitude about accepting or refusing services which are offered. Some of the specific behaviors which may indicate a need for protective services include instances in which the client:

(1) is so forgetful or otherwise mentally disorganized as to neglect activities of daily living;
(2) neglects his/her personal hygiene and/or refuses to eat, and/or is ill and refuses to receive medical care;
(3) is inappropriately dressed, i.e. not dressed for protection in cold weather or wearing winter clothing in extreme heat;
(4) is oblivious of, or refuses to correct or leave unsanitary or hazardous living conditions, or creates situations hazardous to self or others;
(5) gives money or possessions away; spends or hoards money and goes without essentials; constantly loses checks or money, keys, food stamps; does not open mail; fails to pay rent or other bills;
(6) is unaware or too incapacitated to protect self from abuse, neglect or exploitation (financial, physical, psychological or sexual);
(7) isolates self, locks or barricades self in home;

(8) over or under medicates or attempts suicide or otherwise causes self injury; acts bizarrely, hallucinates or is disoriented as to person, time and place; wanders off; or (9) causes injury to others or repeatedly causes disturbances in the community.

c. As noted above, progress notes must include a record of contacts with other divisions/units of the local social services district or other agencies. All requests for assessments, benefits and/or services for a PSA client as well as conferences, consultations and conversations with staff of other divisions/units or agencies must be documented in the progress notes. This documentation must at a minimum include:

(1) name of the person contacted and the agency or division/ unit they represent;
(2) date and type of contact;
(3) the issues discussed during the contact; and
(4) agreements or understandings reached during the contact.

d. In addition, each district must have a procedure to follow if another division/unit of the local social services district or another agency does not respond to a request for an assessment, services, benefits or another inquiry concerning the delivery of services to a PSA client. This procedure must include provisions for reasonable follow up efforts by PSA workers, and their supervisors with their counterparts in other divisions/units or agencies. All follow up contacts by workers and their supervisors must be documented in the progress notes as described above. If these follow up efforts are not successful, supervisors must advise their local commissioner or designee of the situation. E. Required Client Contacts

Section 457.5(b) of the regulations sets forth the standards regarding required contacts with PSA clients. PSA staff must maintain regular contacts with PSA clients as frequently as necessary to assure that the services needs of the individual are adequately met. The purpose of these client contacts is:

1. to determine what progress has been made towards achieving the services plan;

2. to identify and assess any problems that may be present that affect achieving the services plan or threaten the client's safety or well being; and

3. to determine what adjustments, if any, need to be made in the services plan or in the tasks associated with the implementation of the services plan. The frequency of contacts to a PSA client depends on:

1. the specific circumstances of the individual's situation;

2. the ability and willingness of family members, friends and neighbors to assist the individual; and

3. the involvement of other agencies in the provision of services to the individual.

The frequency and type of client contact is determined by the worker in consultation with the PSA supervisor as a part of the PSA assessment process.

At a minimum, face to face contacts must be maintained with all PSA clients every calendar month. All PSA clients also must be visited in their homes at least once every three calendar months. Face to face contact can occur in the office, in a client's day program, in a senior center, or in any other setting. Every effort should be made to arrange for client contacts in locations that best meet the needs of the clients. However, PSA clients who meet any of the following three criteria must be visited in their home at least once every calendar month:

1. The client is a suspected or documented victim of abuse, neglect or exploitation by another person: If there is a reasonable suspicion or specific evidence that the client is a victim of physical abuse, sexual abuse, psychological abuse, financial, or other material exploitation, active neglect or passive neglect by others, as defined in Section 473.6 of the Social Services Law and in 95 INF-38, a home visit is required at least once every calendar month.

2. Environmental conditions exist in the home which are a threat to the health and safety of the client: If a client's living conditions present health and/or safety risks, a home visit must be made at least once every calendar month. Health and safety risks include, but are not limited to; serious unsanitary conditions, fire hazards, and the lack of utilities and/or water.

3. when a client is homebound or when there is no other way to have face to face contact with the client without a home visit: If a client is unable, due to mental or physical impairments, or unwilling to leave home, or if a face to face contact cannot be arranged outside of the client's home, a home visit must be made at least once every calendar month.

Required home visits may be delegated to the professional casework or social work staff of another public or voluntary agency if all of the following conditions are met: 1. the case is stabilized;

2. the other agency agrees to submit written monthly status reports which become part of the client's case record;

3. the district evaluates the status reports submitted by the other agency; and

4. the local social services district caseworker visits the client within 72 hours of the receipt of the status report, if the report indicates that there has been a change in the client's circumstances.

The following client contact requirements pertain to PSA clients in certain types of facilities:

1. PSA clients who are permanent residents of residential care facilities do not need to be visited. PSA staff must maintain telephone contact with facility staff to monitor the client's condition at least once every three months.

As discussed in 89 ADM-22, "Residential Placement Services for Adults", there are situations in which PSA staff may have to take a more active role on behalf of a PSA client who is a resident of a FTHA. These situations include the inability of a FTHA operator to meet the needs of the resident or to protect the resident from abuse, neglect or exploitation by others outside of the home. In these situations, PSA staff must work with the district's Family Type Home Coordinator and take the necessary actions to protect the client and assure that his/her needs are met. In these situations, the type and frequency of contact with the client will be determined by the seriousness of the situation.

2. PSA clients who are hospitalized do not need to be visited. PSA staff must maintain monthly telephone contact with hospital discharge planning staff in order to monitor the client's condition and to plan for the discharge of the client to his/her home or another appropriate setting.

3. PSA clients who are incarcerated do not need to be visited. PSA staff must maintain monthly telephone contact with facility staff in order to monitor the client's condition and to plan for his/her release to the community.

The client contact requirements for persons in certain types of facilities, as presented above, do not supersede the provision contained in Section 81.20 of Mental Hygiene Law that requires guardians to visit persons for whom they are acting as guardian at least four times a year. Therefore, if a commissioner is acting as guardian for a PSA client in one of the aforementioned facilities, at least four visits must be made annually to the client in accordance with this requirement, or more often if required by the court order appointing the guardian.

In addition to contacts with clients, caseworkers must maintain regular communications with all persons involved in the care of their clients. These communications are essential to good case management, an important PSA function, and the delivery of quality services to PSA clients. While ideally, a case conference should be held and a joint case plan developed in all PSA cases in which

other persons or agencies are involved in the client's care, such a blanket requirement is unrealistic. However, there should be regular, open and collaborative discussions of the client's case plan among all involved parties. Whenever possible, the client should be involved in these discussions.

To ensure that client contact requirements are met, diligent efforts must be made to schedule client contacts and visits at times and locations that will ensure their success. For example,

the caseworker should determine the days of the week and times of day that a client is most likely to be at home and schedule home visits accordingly. For other client contacts, caseworkers should determine the days and times of day when it is most feasible to schedule office visits with the client or to meet the client at an agreed upon location. If a scheduled home visit or other required contact cannot be made, it is expected that at least one additional attempt will be made to complete the required visit or contact unless unforseen circumstances beyond the control of the district are present. If a second attempt to make a home visit or other required client contact is unsuccessful, the need for additional attempts to make the required visit or contact must be evaluated by the caseworker and supervisor based on the particulars of the case. If unforseen circumstances, such as a client's failure to keep a previously arranged appointment(s) or weather conditions which make travel impossible, prevent the completion of a required home visit or other client contact, alternative measures must be made to verify the client's safety. Alternative verification measures include making telephone contact with the client if he/she can be expected to accurately report on his/her situation, or making personal or telephone contact with a reliable collateral source.

In situations in which there is a real danger of physical harm to a PSA worker that cannot be alleviated by sending an additional staff person on the visit or obtaining police assistance, an alternative arrangement must be made for client contact. The alternative arrangement must be approved by the supervisor.

In all cases in which a required client contact or visit cannot be completed due to the circumstances described above, the particulars of the situation, the diligent efforts made by the district to contact or visit the client and the alternative methods used to verify the client's safety must be reflected in the progress notes. F. Services Plan Implementation

Sections 457.5 and 457.6 of the Department's regulations require districts to provide services to meet the individual needs of PSA clients, including arranging for appropriate involuntary legal interventions. Accordingly, PSA staff must complete necessary tasks and take timely action to obtain or provide services that are

proposed in PSA Assessment/Services Plans and Review/Updates. PSA workers must take concrete actions to obtain proposed services within the timeframes established in the Services Plans and Plan Updates, unless the services plan is modified and a reasonable explanation is given for the Trans. No. 96 ADM-18 Page No. 11

modification. Proposed services plan activities must be completed prior to the due date of the next Services Plan Review/Update unless a reasonable explanation is given in the case record why a proposed activity could not be completed. For additional information on the completion and implementation of Services Plans and Updates, please consult 93 ADM-23: "Protective Services For Adults (PSA): Intake".

V. ADDITIONAL INFORMATION

For administrative ease, it is recommended that PSA Assessment/Services Plan Reviews/Updates be coordinated with WMS-Services programmatic eligibility redeterminations.

VI. SYSTEMS IMPLICATIONS

None

VII. EFFECTIVE DATE

October 15, 1996

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Rose M. Pandozy
Deputy Commissioner
Services and Commun

INFORMATIONAL LETTER

TRANSMITTAL: 98 OCFS INF-5

DIVISION: Development and Prevention Services

TO: Local Commissioners of Social Services

DATE: December 1, 1998

SUBJECT: Protective Services for Adults: Mental Health Evaluation Referral Instrument

SUGGESTED DISTRIBUTION: Directors of Services
Protective Services for Adults Supervisors
Protective Services for Adults Caseworkers

CONTACT PERSON: Any questions concerning this release should be directed to your district's State representative of the Adult Services Program:

Kathleen Crowe	(518) 486-3451	or USERID ROF017
Carole Fox	(518) 474-3167	or USERID AX5050
Michael Monahan	(518) 474-9590	or USERID AY3860

ATTACHMENTS: Mental Health Evaluation Referral Instrument

FILING REFERENCES

Releases ADMs/INFs	Dept. Regs. Cancelled	Soc. Serv.	Manual Law & Other Legal Ref.	Misc. Ref.	Previous Ref.
90 INF-16		457.6			

Date December 1, 1998

I. Purpose

The purpose of this release is to inform local districts of a mental health evaluation referral instrument which has been developed in order to assist Protective Services for Adults (PSA) caseworkers in obtaining mental health evaluations for their clients.

II. Background

Part 457 of Department regulations requires PSA staff to obtain mental health evaluations for clients when involuntary interventions are being considered. When involuntary legal interventions, such as Guardianship are being pursued, it is important to document the need for such interventions. This is accomplished by obtaining mental health evaluations which address key functional and cognitive areas of functioning. Local districts have, at times, experienced difficulty in obtaining the specific mental health information necessary in order to plan for and deliver necessary services for PSA clients.

The attached Mental Health Evaluation Referral Instrument has been developed in cooperation with local district PSA supervisors and caseworkers, as well as with clinical staff from state and local mental health agencies. In addition, drafts were sent to Directors of Services in each local district for comment. The recommendations made by local districts have been incorporated into this final product.

This referral instrument was designed to help provide necessary background and referral information on individual clients and to capture the necessary mental health information, such as the ability to make reasoned decisions, the capacity to understand consequences of decisions, and identification of functional and cognitive deficits which impact on the client's ability to function independently without suffering undo harm. Because limiting an individual's freedom is a serious matter, such specific information is crucial when petitioning a court for the authority to undertake involuntary interventions to assure a client's safety and well-being.

III.Implications

We encourage local districts to use the Referral Instrument to facilitate the mental health evaluation process. While its use is not mandatory, the structure of the form should improve the ability of local districts to obtain evaluations which provide the information necessary to serve the PSA client population. It should also be noted that the State Office of Mental Health has been requested to send the Referral Instrument to local mental health providers in order to ensure that they are familiar with it.

Date December 1, 1998

A hard copy of the Referral Instrument is attached to this release. Districts are requested to reproduce it locally. If necessary, contact your PSA representative to obtain a copy.

_____

Donald K. Smith
Deputy Commissioner
Development and Prevention Services

Protective Services for Adults
Mental Health Evaluation Referral Instrument
98 OCFS INF-5

Section I – Referral Information

Agency Referred To: _____ Referral Date: _____

Urgency of this referral: ☐ as soon as possible ☐ 1 wk. ☐ 2 wks. ☐ 30 days

Referring Agency:
_____

Address:
_____

Case Worker: _____ Phone #:
_____

Section II – Client Information

Name: _____ D.O.B.: _____ Social Security #: ___-__-____

Address: _____ Phone:
_____

Insurance or Payment Method: _____ I.D. & Group #:
_____

Client Contact Person: _____ Relationship: _____ Phone:
_____

Section III – Client Information

(To be completed by local district)
Continue information on reverse if necessary, using the appropriate numbers as reference.

1. Reason for this referral:

2. Information that is needed for this evaluation:

3. Client's current situation and presenting problems:

Client's current situation and presenting problems: (continued)

4. Medications being taken:

Medication	Dosage	Frequency	Compliance

5. **History**: (drug/alcohol use, health, education, hospitalizations, other service providers, relevant social history

6. **Available support systems, such as family, programs, agencies:**

Section IV – Evaluation of Capacity and Risk

To be completed by mental health clinician

	YES	NO	COMMENT/EXPLANATION
1. Does this individual have the capacity to make reasoned decisions?			
2. Does this individual have the capacity to understand the consequences of his or her decisions?			
3. Do the individual's choices have a basis in fact and reality?			
4. Is this individual able to function independently?			

5. Functional deficits:			
Orientation			
Memory			
Intellect			
Affect			
6. Is this individual able to provide for personal needs independently?			
6a. If not able to provide for personal needs independently, able with assistance?			
7. Is this individual able to manage finances independently?			
7a. If not able to manage finances independently, able with assistance?			

8. Is this individual likely to suffer harm because of his or her inability to provide for personal or property management needs?			
9. Is this individual at risk of serious harm or death?			
10. Does this individual have the potential for harm to others?			
11. Does this individual require 24 hour supervision?			

Section V – Evaluation Narrative

Please attach an evaluation narrative, which includes the following:

Diagnosis
Please provide a specific diagnosis as this will impact any possible legal intervention.

Recommendations
Please recommend services or interventions, if any, which you determine necessary to meet deficit needs. (e.g. medications, Visiting Nurse, home health aide, mental health counseling, homemaker services, 24-hour supervision, representative payee, out of home placement or other necessary services).

Prognosis
In your opinion, what is the likelihood of this individual's acceptance and cooperation with recommended treatment/services, and the likelihood of the effectiveness of recommended treatment/services?

This mental health evaluation is submitted by:

_____	_____
Signature	Date
_____	_____
Title	Phone

ADMINISTRATIVE DIRECTIVE

NEW YORK STATE DEPARTMENT OF SOCIAL SERVICES
40 North Pearl Street
Albany, New York 12243
Cesar A. Perales, Commissioner

TRANSMITTAL:	88 ADM -023
DATE:	May 23, 1988
DIVISION:	Adult Services
TO:	Commissioners of Social Services
SUBJECT:	Protective Services For Adults: Serving Involuntary Clients
SUGGESTED DISTRIBUTION:	County and Agency Attorneys Directors of Social Services Protective Services for Adult Staff Staff Development Coordinators
CONTACT PERSON:	Any questions concerning this release should be directed to the district's Protective Services for Adult Program Representative at 1-800-342-3715 as follows: Sharon Lane, ext. 432-2985 Kathleen Crowe, ext. 432-2996 Regina Driscoll, ext. 432-2864 Irv Abelman, ext. 432-2980 or (212) 804-1247.

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
87 ADM -006 85 ADM -5 83 ADM -015 82 ADM -032 81 ADM -057 80 ADM -71 86 INF -11 84 INF -13 84 INF -008 79 INF -008	80 ADM -71	Part 457	Article 98 SSL Mental Hygiene Law Family Court Act Public Health Law Surrogate's Court Procedure Act		

DSS-3808 (2/87)

I. Purpose

The purpose of this directive is to clarify the responsibility of local social services districts to provide involuntary services to Protective Services for Adults (PSA) clients under certain circumstances. This transmittal explains and amplifies the Department's regulations and provides guidance in the practical application of involuntary interventions.

II. Background

Although many persons in need of PSA accept services voluntarily, there are a number of involuntary clients who resist the provision of essential services. While local district PSA staff must respect an individual's right to self determination, they also have the legal responsibility to provide necessary services to persons who require them. Authority to protect the life and property of unwilling clients is established in Social Services Law, Mental Hygiene Law, the Fami1y Court Act, Public Health Law and the Surrogate's Court Procedure Act as well as in case law.

Since 1976, when information on the PSA program was first provided by the Department, districts have been reminded of their dual responsibility - protection of the client's rights and protection of the client from harm caused or threatened by reason of the client's incapacities. While the district may not impose a service on a client who is capable of self determination and self care, neither may the district walk away from the client who is threatened with harm, unable to make decisions on his behalf due to impairments and apparently unwilling to accept the needed services.

As part of the Department's PSA case review project to determine compliance with the PSA Process Standards as set forth in Part 457 of the Department's regulations and 85 ADM-5, we have noted that there is still considerable confusion among local staff

regarding the responsibi1ity of districts to provide services to involuntary PSA clients. This directive is intended to provide needed clarification to local districts.

III. Program Implications

The information presented below amplifies Department policy, as set forth in applicable laws and regulation, regarding the delivery of services to involuntary PSA clients. This information should enhance the capability of district staff to serve involuntary PSA clients by providing them with a more thorough understanding of:

- the situations in which the district has a responsibility to provide services to involuntary PSA clients; and
- the legal interventions which are available to assist districts in the delivery of appropriate services to PSA clients.

A. GENERAL INFORMATION

PSA staff should give primary consideration to the individual rights of clients. To the fullest extent possible, clients should be supported by the caseworker in exercising free choice in making decisions, especially those which may involve significant changes in a client's life. A majority of individuals requiring PSA will become voluntary clients when informed of the services available to them. The establishment of trust and respect between worker and client, appropriate counseling and gentle persuasion will often help a resistive client accept services on a voluntary basis. The initial emphasis of the caseworker's efforts must generally be in this direction. PSA staff also must attempt to work with members of the client's family, friends and other persons of significance to the client, including staff of other agencies serving the client, to convince a resistant c1ient to accept services voluntarily.

It is not always possible to convince an endangered client to accept necessary services. Some clients may be so impaired that they are totally unable to comprehend their situation. Other less impaired clients may be able to meet certain basic needs but unable to meet others. When, after a thorough assessment of a client's current situation, there is evidence of a serious threat to the safety and well being of the client and the client is incapable of making choices regarding the danger because of temporary or permanent impairment, the agency is obligated to secure services to ensure the client's safety, even if the client refuses them. Because the ability of the client to make decisions on his behalf is always a consideration when involuntary interventions are being considered, it is advisable to arrange for a mental health evaluation of the individual prior to pursuing any legal intervention.

In considering involuntary intervention, it is important to distinguish between incapacity and incompetence. Incapacity means an inability to function in a given area. A person lacking capacity in one area can retain capacity and rights in other areas. Incompetence is a legal term which refers to a conclusion reached in a court of law that a person is

incompetent to manage himself or his affairs. Incompetence means that the person lacks capacity in all areas. Most PSA clients who require involuntary interventions will be incapacitated, rather than incompetent.

It is important that PSA staff have a basic understanding of the appropriate provisions of law and the practical legal issues they must face on a daily basis with their clients. It is equally important that a strong collaborative relationship be established with the professional legal staff assigned to the agency. If legal action is required, the agency attorney will be needed to prepare the case and present it before a judge, often on short notice. PSA staff must first identify the case as meeting the legal criteria for the appropriate form of intervention and recommend a course of action. The attorney must also be provided with documented evidence of the client's situation and need for the form of intervention recommended by the caseworker and his/her supervisor. A well prepared and well documented case generally results in a successful outcome in court.

The consequences of intervention contrary to the wishes or without the consent of a client cannot be taken too seriously, and such action should be contemplated only after reasonable attempts have been made to secure the client's cooperation. If an involuntary intervention is being considered, the principle of "least restrictiveness" must be carefully observed at each step in the development of an involuntary plan of care. It must be emphasized that this does not mean that intervention is to be avoided. It does mean that each intervention must be limited in scope and include only those specific actions required to eliminate the existing endangering conditions and ensure the client's continued safety and well-being. If involuntary actions are required, to the extent possible, efforts should always be made to provide services in the client's own home with as little disruption to his chosen lifestyle as possible. There are, of course, circumstances in which a client's safety is seriously threatened in his current environment, and removal must be considered. If temporary removal from the client's home is required, every effort must be made to safeguard and maintain the house, and to return the adult to his home as soon as the conditions which necessitated removal are alleviated.

In some situations, it may not be possible to provide the services necessary to ensure the client's safety in his own home. If long term alternative living arrangements and residential placement are required, the client must be involved in the placement decision to the fullest extent possible consistent with his level of impairment. PSA staff should be actively involved in counseling the client and his family throughout the placement process. The district must make every effort to locate and provide advocacy in placing the client in the setting most appropriate for the client's needs.

There are two traditional legal principles, based in the Common Law, under which intervention may be pursued: the police power of the State, which gives the State authority to regulate activities that endanger the health and safety of other persons in society and the theory of parens

patriae, which gives the State authority to act in a parental capacity for persons who cannot care for themselves or who are dangerous to themselves. These two principles provide a common law basis for the provision of PSA.

In addition to these common law underpinnings, the Social Services Law provides explicit statutory authority for PSA. Local social services districts are mandated by Section 473 of the Social Services Law (SSL) to provide Protective Services for Adults. Services provided under PSA include: receiving and investigating reports of seriously impaired individuals who may be in need of protection; arranging for medical and psychiatric services; arranging for commitment, guardianship, conservatorship or other protective placement; cooperating and planning with the courts as necessary on behalf of individuals with serious mental impairments; and other specific protective services as set forth in the Consolidated Services Plan (CSP). Section 457.6 of the Department's regulations further states, "When the district believes that there is a serious threat to an adult's well-being and that the adult is incapable of making decisions on his or her own behalf because of mental impairments, the local social services official has a responsibility to pursue appropriate legal intervention ..."

Although local districts are mandated to provide PSA as noted above, additional authority to protect the life and property of unwilling clients is established in Mental Hygiene Law, the Family Court Act, Public Health Law and the Surrogate's Court Procedure Law, as well as Social Services Law. The immediacy and seriousness of the threat to the individual determine whether crisis intervention procedures and/or other legal procedures are warranted as set forth below. Districts have the authority as well as the responsibility to utilize these procedures in appropriate situations on behalf of involuntary PSA clients.

B. INVESTIGATING PSA REFERRALS

Local district staff sometimes encounter serious difficulties in investigating PSA referrals because they are unable to gain access to the potential client. Access is denied either by the subject of the PSA referral or by a family member or friend acting as the person's caregiver. Often the caregiver denying access to the potential client is suspected of abusing or exploiting this individual. In order to respond to these cases, local district staff enlist the assistance of family members, friends, neighbors or staff from other agencies already known to the potential client in order to gain access. However, there are still situations where local district staff cannot gain access. In those cases, staff are advised to request assistance from law enforcement personnel. However, the ability and willingness of law enforcement personnel to effectively intervene vary greatly depending on the specific situation and the individual police jurisdiction involved. Section 473-c SSL addresses this problem by providing a mechanism for local districts, in conjunction with law enforcement personnel, to utilize in order to gain access to persons believed to be in need of PSA. Specific information regarding the steps to be taken to effectively utilize Section 473-c SSL may be found in 87 ADM-6.

C. CRISIS INTERVENTION

State law contains several specific interventions which can be utilized in crisis situations. For purposes of this directive, a crisis is defined as a situation in which there is an immediate and identifiable danger to a person or his property and the person, because of impairment, regardless

of cause or duration, is incapable of making the choices necessary to remove the endangering condition.

1. Social Services Law (SSL): Short Term Involuntary Protective Services Orders (STIPSO)

Chapter 991 of the laws of 1981 established Section 473-a SSL, which authorizes local social services districts to petition a court for a STIPSO on behalf of certain PSA clients who are at imminent risk of death or serious physical harm and are unable to understand the consequences of their situation. This law was enacted in large part because PSA staff had often been unable to take the necessary immediate action to insure the safety of their clients, who, although unable to comprehend the seriousness of their situation, could not be admitted to a psychiatric facility under Mental Hygiene Law (MHL) because their condition was not the result of mental illness. Because of the need for expeditious action, the provisions of MHL governing the appointment of conservators and committees were also of limited assistance due to the time consuming nature of these proceedings. Specific information regarding procedures for implementing the STIPSO statute can be found in 81 ADM-57 and 82 ADM-32. Information regarding the utilization of STIPSO may be found in 86 INF-ll.

2. Mental Hygiene Law (MHL)

a. Involuntary Admission to a Psychiatric Facility

Section 9.47 of MHL provides that directors of community services, health officers and commissioners of social services have a duty to see that all mentally ill persons within their respective communities in need of care and treatment at a psychiatric hospital receive appropriate care. Therefore, the local district has a responsibility to obtain treatment for mentally ill individuals found in the community who are unable to function on their own, are acting in a manner likely to cause harm to themselves or others, and have no other responsible person or service provider available to provide the necessary help.

It is important that the concept of harm to oneself or others be understood within the context of Mental Hygiene Law. The "likelihood to result in serious harm" is defined in MHL to mean "a substantial risk of physical harm to himself as manifested by threats of or attempts at suicide or serious bodily harm or other conduct demonstrating that he is dangerous to himself," or "a substantial risk of physical harm to others as manifested by homicidal or other violent behavior by which others are placed in reasonable fear of serious physical harm" (Section 9.39
MHL).

The following actions must be initiated in appropriate situations by local districts on behalf of persons who appear to be "mentally ill" and "in need of treatment" and whose behavior can be documented to indicate a "likelihood to result in harm" to themselves or others.

1) Enlist the Immediate Assistance of a Peace Officer (Section 9.41MHL)

Any peace officer of the state, town, village, county or city who is a member of the State Police or of an authorized police department or force or of a sheriff's department may take into custody any person who appears to be mentally ill and is conducting himself in a manner which is likely to result in serious harm to himself or others. The officer may direct the removal of such person or remove him to a hospital with appropriate staff and facilities to care for mentally ill persons. (It is important to emphasize that the decision to admit an individual to a psychiatric facility rests with the facility.)

2) Request Action by the Local Director of Community Services (Sections 9.37and 9.45 MHL)

The director of community services, usually the county Mental Health Commissioner or his official designee, has the authority to examine and remove a mentally ill person to a psychiatric facility for treatment and care. In addition, the director has the authority to direct any state, county or local peace officer to transport the individual to the facility when required. (However, the decision to admit the person to the facility rests with the facility.)

3) Initiate Application for Admission to a Mental Facility on Certification of Two Physicians (Section 9.27 MHL)

A social services official is authorized to initiate the application for admission to a psychiatric facility on behalf of a mentally ill individual who needs involuntary care. The application must contain a statement of the facts upon which the allegation of mental illness and need for involuntary care is based. The application must be accompanied by the certificates of two examining physicians. (Again, it must be emphasized that the decision to admit the individual to a psychiatric facility rests with the facility.)

b. Admission of Involuntary or Non-Objecting Persons to a Developmental Center

A separate section of MHL gives certain public officials, including commissioners of social services, explicit authority to initiate applications for admission to developmental centers on behalf of mentally retarded individuals. The local districts must initiate the following actions on behalf of persons alleged to be mentally retarded and in need of involuntary care and treatment.

1) Involuntary Application for Admission to a Developmental Center on Medical Certification (Section l5.27 MHL)

A social services official is authorized to initiate an application for admission to a developmental center on behalf of an individual who is alleged to be mentally retarded

and in need of involuntary care and treatment. The application must contain a statement of facts upon which the allegation of mental retardation and need for involuntary care and treatment are based and must be accompanied by the certificates of two examining physicians or of one examining physician and one certified psychologist. (The final decision to admit the individual to a developmental center rests with the facility.)

2) Application for Admission to a Developmental Center on Behalf of Certain Non-Objecting Adults (Section 15.25 MHL)

A social services official is authorized to initiate an application for admission to a developmental center on behalf of an individual in need of care and treatment who does not object but who is so profoundly or severely retarded that he does not have sufficient understanding to give informed consent. The application must conform to the requirements set forth in Section 15.27 MHL (discussed above) and must be accompanied by the certificate of one examining physician or certified psychologist.

c. Temporary Restraining Order to Protect the Property and Welfare Of a Proposed Conservatee (Section 77.O8 MHL)

Chapter 489 of the Laws of 1982 amended Article 77 MHL to expand the powers of the court to provide provisional remedies which offer immediate protection of the property and welfare of a proposed conservatee pending the appointment of a conservator. Under the provisions of Section 77.08 MHL, a petition may be made in county or supreme court, upon a showing of good cause, for the issuance of a temporary restraining order preventing any specified person from affecting the property of the proposed conservatee, or from committing an act or allowing an act of omission which could be shown to endanger the welfare of the proposed conservatee. In addition, the law empowers the court to give any such temporary restraining order the effect of a restraining notice to persons having custody or control over the person or property of the proposed conservatee, thereby prohibiting the sale, assignment, transfer or interference with any property of the proposed conservatee, except pursuant to court order.

This statute provides the districts with an effective tool in situations in which a PSA client is unable to protect himself or his property from the neglectful or exploitive actions of another person and prompt action is required to protect the client from further harm. This action must follow a formal petition for conservatorship. Conservatorship proceedings are discussed in greater detail below.

3. Family Court Act (FCA): Orders of Protection

Article 8 of the Family Court Act (FCA) may be utilized to obtain orders of protection on behalf of adults who are victims of abusive or neglectful acts by a child or other member of the family or household. Petitioning a court for an order of protection is a civil proceeding. It provides an

alternative to criminal prosecution of the abusive family member or other actions taken on behalf of the abused PSA client which often may result in their removal from the home.

At a minimum, a petition to Family Court for an order of protection must contain an allegation that the accused abuser has committed acts which would constitute disorderly conduct, harassment, menacing, reckless endangerment or assault in the second or third degree, and a statement of the relationship of the alleged offender to the petitioner (Section 821 FCA). Examples of these actions include physical abuse and preventing or interfering with the delivery of essential services and care, including hospitalization and residential care. Whenever possible, abused persons should be encouraged to file for an order of protection on their own behalf. The Family Court Act, however, also authorizes local public welfare officials and representatives of other duly authorized agencies to initiate proceedings for orders of protection (Sections 119 and 822 FCA). The Family Court does not require physical or mental impairment as a prerequisite for issuance of an order of protection on behalf of an adult for whom a third party has initiated a petition. However, it is recommended that districts include any available documentation regarding the client's impairment and inability to protect himself.

Following the filing of a petition, a Family Court may, upon a showing of good cause, issue an immediate temporary order of protection. A temporary order can provide the protection requested before the matter has been fully investigated and decided. It may set forth any "reasonable conditions of behavior" to be observed by the respondent or any other family or household member. Often a situation may be resolved following the issuance of a temporary order of protection with no further court action required. (Section 828 FCA)

Following a hearing and based on a finding that the allegations are "supported by a fair preponderance of the evidence", the Family Court may issue a permanent order of protection, which may remain in effect for up to one year. (Section 842 FCA)

4. Public Health Law (PHL): Situations Where There Is A Danger to the Public Health and Safety

In those situations where the physical health and safety of the client or others is put in jeopardy because of dangerous or unsanitary living conditions, districts should enlist the help and cooperation of local public health officials. Such officials are authorized to investigate complaints of unsanitary or unsafe conditions affecting the public health. It is within their scope of responsibility to cite violations and, if the violations are not removed, file appropriate charges which are subject to fine or imprisonment. Public health officials, upon failure of a property owner to comply with a duly executed order, may enter a premises and remove and/or suppress any condition which is determined to be "detrimental to the public health." In most situations, the official citation of violations may be sufficient to stimulate corrective action or the client's acceptance of services (Sections 1303-1305, 1308,2120 PHL).

5. Parens Patriae: Court Orders to Obtain Medical Treatment

Under the common law principle of "parens patriae", which is discussed above, the State Supreme Court has the authority to issue orders for medical treatment on behalf of certain

seriously impaired adults who are unable to act for themselves. Case law gives the court authority to appoint guardians and receivers to protect the interests of disabled adults or to give consent for medical treatment. Courts engage in a case by case review of the specific facts presented. Examples of case law include Weberlist, 360 NYS 2d 783 (Sup. Ct., NYC, 1974); New York City Health and Hospital Cor. v. Stein, 335 NYS 2d 461 (Sup. Ct., NYC, 972; Matter of Roosevelt Hospital NYLJ Jan. 13, 1977 (Sup. Ct., NYC); and Matter of Storar, 438 NYS 2d 266 (1981), cert. den. 454 U.S. 858 (1982).

Courts may, under other statutes, appoint a conservator (Article 77 MHL), committee (Article 78 MHL) and Guardian for the Mentally Retarded (Article 17-A, Surrogate's Court Procedure Act) and authorize that person, under court supervision, to make certain specified medical decisions. Courts, however, do not have the authority to authorize intrusive medical procedures with a STIPSO under Section 473-a SSL.

Local district staff are responsible, where appropriate, for arranging for medical services for PSA clients. This is usually accomplished through referral to other appropriate agencies. However, situations do arise in which a PSA client urgently requires a specific medical intervention, such as surgery, and is unable, due to mental and/or physical impairments, to make an informed decision to proceed with the needed treatment and does not have a court appointed surrogate. In these circumstances, it may be necessary for the district to be involved in pursuing a court order to obtain medical treatment. It should be noted that neither an adult child, the parent of an adult child nor a local social services official may lawfully make substitute decisions regarding medical treatment on behalf of another adult without first obtaining a specific court order except in certain limited instances involving psychiatric inpatients.

Careful consideration is necessary when determining whether to seek a court order to impose medical treatment against the wishes of an impaired adult. Even with a non-resistant adult who is considered too impaired to provide "informed consent", a court order must be sought to provide medical treatment. Under all circumstances, medical intervention should be limited to the least restrictive appropriate measure.

In certain emergency situations in which consent is not "reasonably possible", such as in the case of a seriously mentally disabled individual who needs emergency surgery, it is legally defensible for a hospital to provide treatment in the absence of the patient's informed consent (Section 2805-d PHL).

D. LEGAL PROCEDURES OF LONG TERM CONSEQUENCES

The following legal interventions involve the use of court procedures which provide for long term management of the property or the property and person of impaired individuals by court appointed surrogates. These procedures require more time to implement than is afforded in emergency or crisis situations. They are to be initiated only for persons who have demonstrated such a degree of incapacity that supportive services alone are not adequate to achieve a plan of protection. These procedures are set forth in Articles 77 and 78 of MHL and Article 17-A of the

Surrogate's Court Procedure Act, which govern the appointment of conservators, committees and guardians for the mentally retarded. Conservatorship and committee proceedings are initiated in the Supreme Court or County Court, while guardianship for the mentally retarded proceedings are initiated in the Surrogate's Court. A discussion of the Community Guardian Program follows a discussion of the above-noted procedures.

1. Conservator

Article 77 of MHL sets forth the procedures for the designation of a conservator for the property of a person who has not been declared to be incompetent by a court but who "by reason of advanced age, illness, infirmity, mental weakness, alcohol abuse, addiction to drugs, or other cause, has suffered impairment of his ability to care for his property or has become unable to provide for himself or others dependent upon him for support." Any "friend" of the proposed conservatee, including a relative, a corporate body, a public agency or a social services official may initiate a conservatorship proceeding and act as a conservator.

The primary duties of a conservator are to preserve, maintain and care for the proposed conservatee's income and assets. The court must, however, approve a plan for the conservator to provide for the conservatee's well-being, including the provision of necessary personal and social protective services to the conservatee. Therefore, the court may grant additional powers to a conservator, including control over personal care and placement decisions, which are specified in the court order. Although several conservatorship orders have given the conservator the authority to make placement decisions, not all courts are willing to do so.

The following proof/documentation regarding the proposed conservatee must be presented to the court:

- the reason for concern for the financial and personal well-being of the individual;

- clear and convincing proof of the need for a conservator, including proof of functional impairment (an assessment by a mental health professional is not required by law, but may be required by the judge);

- the name and address of the proposed conservatee, his spouse, his legal heirs and the person or agency, if any, currently having custody of his person;

- the nature, probable value and income of all property;

- the anticipated duration of the conservatorship, and if indefinite, why a fixed period is not more appropriate;

- the extent of income and assets to be placed under the conservatorship and the necessity for so doing; and

- the petitioner's proposed plan to insure the preservation, maintenance and care of the proposed conservatee's income, assets and personal well-being, including the provision of necessary personal and social protective services to the conservatee.

The local social services district must first determine if there is another interested and responsible person or agency to file the petition and act as conservator on behalf of a PSA client. If no one else is willing or capable of acting in this capacity, the district must apply for conservatorship as required by Section 457.1(c)(9) of the Department's regulations.

A notice of the conservatorship petition must be served on the proposed conservatee, his spouse and children, or if none are known, his legal heirs, or if none are known, the person with whom he resides or the director of the facility in which he resides. The court may appoint a guardian ad litem to represent the interest of the proposed conservatee. The guardian must fully investigate the situation and arrive at a finding for presentation to the court. A hearing will take place before the judge unless the court determines that a trial by jury is appropriate, for reasons stated in the law. Local districts must act as a conservator for a PSA client if no one else is willing and capable of acting in this capacity. An annual accounting and inventory must be filed with the court every January. If the district is named conservator, the client's estate must be managed in accordance with the requirements set forth in 83 ADM-15 and briefly discussed in the following section entitled Financial Management Procedures.

Article 77 MHL contains a provision for a temporary restraining order to protect the property and welfare of a proposed conservatee when there is a need for prompt intervention. This is described in greater detail in Section B.2.c. above.

2. Committee

Article 78 of Mental Hygiene Law sets forth the procedures for the appointment of a committee for a person who is incompetent to manage himself or his affairs. Anyone may commence a special proceeding to declare a person incompetent and to appoint a committee of an incompetent. Where the property of any person is endangered by reason of his incompetence and no proceeding has been commenced, the local social services commissioner is required to bring the proceeding (Section 78.03 MHL).

The essential element in the establishment of a committee is the finding by the court that the adult is legally incompetent. This results in a substantial reduction in personal civil rights. It is not a procedure to be pursued for persons who are only partially or sporadically impaired in their functioning and are capable of retaining some independence. The totality of both the disability of the affected person and the duties and powers of the committee, albeit subject to the supervision of the court, are strong reasons why a committee proceeding should only be considered when it is clear that an adult is severely and permanently impaired and no less restrictive measures would suffice. Additionally, Section 78.02 MHL requires that, prior to the appointment of a committee, the court must

first consider whether the interests of the individual could best be served by the appointment of a conservator.

The procedure to be followed in the establishment of a committee is basically the same as that for a conservatorship (discussed above).

3. Guardianship for the Mentally Retarded

Article l7-A of the Surrogate's Court Procedure Act established a procedure for the protection of persons who are mentally retarded. The law provides for the appointment of a guardian for a mentally retarded person who is certified as incapable of managing himself and/or his affairs because of permanent mental retardation. The certification must be made by at least two licensed physicians, or a licensed physician and a certified psychologist. The guardian may be appointed over the person, the property or both. Parents, relatives or other interested persons may be appointed as guardian. A non-profit corporation may be appointed as corporate guardian of the person only. A standby guardian may be appointed by the court to assume guardianship upon the death of the guardians/parents.

Because case management responsibility for individuals who have been formally diagnosed as mentally retarded is generally assumed by other agencies, local social services districts probably will have limited involvement in this area. However, in accordance with Section 473.l(c) and (e), SSL and Section 457.l(c)(7) of the Department's regulations, local districts must petition for the appointment of a guardian of the mentally retarded in appropriate situations where no one else is willing and able to act on behalf of the client. The process and information to be presented to the court is similar to that for conservatorship and committee, with the exception of the need to present a certification of mental retardation. The agency attorney should be consulted immediately if it appears necessary for the district to pursue guardianship.

4. Community Guardian Program

Section 473-c SSL established a Community Guardian Program which allows a social services official to contract with a non-profit organization or government agency to serve as conservator or committee for PSA clients. Under provisions of this statute, the local social service official may bring a petition to appoint a conservator or committee under Article 77 or 78 MHL for a person who is:

- o eligible for and receiving PSA;
- o living outside a hospital or residential facility or able to return to the community if a conservator or committee is appointed; and o without capable friend, relative
- or agency willing to serve as conservator.

Upon being appointed conservator or committee, the Community Guardian Program must:

- o make best efforts to maintain the person in the community;
- o obtain medical, social, mental health, legal and other services that are available and required for the person's safety or well-being;
- o advocate for all entitlements, public benefits and services for which the person qualifies and which the person requires; and
- o obtain an annual assessment from two qualified psychiatrists or a qualified psychiatrist and a qualified psychologist to determine if services are still required.

Additional information regarding the Community Guardian Program may be found in Section 457.12 of the Department's regulations.

E. FINANCIAL MANAGEMENT

Many PSA clients will have limited or no ability to manage day-to-day financial transactions and/or protect themselves from exploitation. Sometimes financial management is the client's primary need. A client's inability to manage his finances may result in failure to pay essential bills, wasting of resources, and/or failure to purchase adequate food, clothing, shelter or medical care. This inability may also leave them vulnerable to exploitation by others, which can include unauthorized use of a client's telephone or property, theft of food or household possessions, unauthorized withdrawals from bank accounts, and refusal to purchase essential goods and services by a caregiver who controls the client's funds.

In accordance with the requirements of Section 473 SSL and Part 457 of the Department's regulations, districts must be prepared to provide certain financial management services to their PSA clients. Section 457.l(c)(4) of the Department's regulations requires local districts to provide counseling to PSA clients and their families, which includes advice regarding the use of the client's funds. Section 457.l(c)(9) requires the districts to function as conservator, representative payee or protective payee when these services are determined to be necessary and no other individual or agency is willing and capable of providing them.

The Social Security Administration can designate a representative payee to receive cash benefits on behalf of a beneficiary receiving either OASDI or SSI benefits when there is positive legal, medical or other acceptable evidence presented which establishes that the beneficiary is unable to manage his assets or protect his interests by reason of physical or mental impairment. Other retirement systems have established procedures similar to those of the Social Security Administration for appointing fiduciaries on behalf of beneficiaries who are unable to manage their

benefits. The Railroad Retirement System uses the term "representative payee" and the Veterans Administration uses the term "fiduciary" or "custodian". When it becomes apparent that a PSA client is in need of the appointment of a representative payee (or fiduciary or custodian), every effort should be made to involve a legal guardian, relative or friend as the representative payee. If no responsible person can be found to act in this capacity, the local district commissioner must apply to be designated as representative payee.

Part 381 of the Department's regulations includes procedures designed to address the needs of clients who by reason of mental or physical incapacity are unable to manage their public assistance grants. One mechanism involves protective payments, i.e. the issuance of the client's ADC or HR grant to an individual other than the recipient when the client has demonstrated an inability to manage funds. This payment may be made to a staff member of the local social services district, preferably staff providing protective services.

Additional information regarding financial management services and the Department's requirements for a written financial management system may be found in 83 ADM-15, 84 INF-8 and 79 INF-8.

F. IMMUNITY FROM CIVIL LIABILITY

Local social services staff often have concerns regarding the potential liability of the agency and themselves in civil lawsuits initiated on behalf of PSA clients. While these issues are generally of greatest concern in the context of providing services to seriously at risk involuntary clients, they also pertain to voluntary clients. Laws providing immunity from civil liability for local district PSA staff and individuals who make good faith reports of persons in need of PSA are discussed below. Additionally, it should be noted that districts are usually more liable for not acting on behalf of an impaired adult than for taking actions they deem appropriate.

1. Immunity of Public Officials

Section 473.3 SSL provides explicit immunity from civil liability for any social services official or his designee involved in the provision of PSA. This subdivision of the law reads as follows:

> "Any social services official or his designee authorized or required to determine the need for and/or provide or arrange for the provision of protective services to adults in accordance with the provision of this section, shall have immunity from any civil liability that might otherwise result by reason of providing such services, provided such official or his designee was acting in the discharge of his duties and within the scope of his employment, and that such liability did not result from the willful act or gross negligence of such official or his designee."

Although this law provides immunity from civil liability for PSA staff acting in the discharge of their duties and within the scope of their employment, it does not prevent them from being sued. The law does, however, provide PSA staff and the local districts with a strong legal defense for responding to such lawsuits.

2. Immunity for Persons Who Report Endangered Adults or Persons in Need of Protective Services

Chapter 523 of the Laws of 1984 established Section 473-b SSL, which provides immunity from any civil liability to persons who in good faith believe that an adult may be endangered or in need of protective services, and who report or refer such person to the Department, the State Office for the Aging, any local social services district, area agency on aging, law enforcement agency, or any other person, agency or organization that the reporters believe, in good faith, will take appropriate action. The immunity provision also extends to persons who testify in any judicial or administrative proceeding which results from a report or referral.

Immunity from civil liability may encourage referral sources and other persons whose testimony may be necessary in a judicial or administrative proceeding to disclose more information to local district staff during the course of PSA investigations. As with the immunity law for PSA staff, this law is not a guarantee against lawsuits. It does, however, provide a strong legal defense for responding to such lawsuits. Local districts should make other local agencies and referral sources aware of this statute. Additional information regarding immunity for reporters may be found in 84 INF-13.

IV. Required Action

A. Local commissioners must assure that a procedure is in place which ensures the availability of the local agency's legal staff for prompt consultation with PSA staff when requested and timely implementation of legal interventions on behalf of PSA clients in appropriate situations. This procedure must assure that in those situations where there is a disagreement between services and legal staff about the appropriateness of a legal intervention on behalf of a PSA client, the matter will be promptly referred to the local commissioner or his designee, who wi1l make the decision on whether to pursue legal action.

B. PSA and legal staff must familiarize themselves with the range of interventions set forth in this directive which can be utilized on behalf of involuntary PSA clients and the situations in which each of these interventions can be appropriately employed on behalf of the client.

C. Since involuntary interventions will often require the involvement of other agencies, local districts must continue their community education/networking activities in accordance with Section 457.7 of the Department's regulations, including meetings with representative community agencies for the purpose of establishing specific agency roles and areas of responsibility in the provision of PSA.

D.1. As noted above, when involuntary interventions are being considered, it is advisable to arrange for a mental health evaluation of the client. Usually, such an evaluation is conducted in the client's home by a qualified menta1 health professional. The State Office of Mental Health (OMH) has indicated that local mental health departments, in accordance with their service planning and delivery responsibilities set forth in Section 41.01 and 41.13 of the Mental Hygiene Law (MHL), are responsible for providing or arranging for the provision of mental health evaluations by qualified personnel on behalf of involuntary PSA clients when the district is contemplating legal intervention. Therefore, local districts must establish a process to obtain such evaluations through the local mental health department. Depending on the service delivery structure of a given locality, these evaluations should be provided either by the mental health department, a voluntary agency under contract with the mental health department, or the State Psychiatric Facility serving that geographic region. The State Office of Mental Health also has advised us that mental health evaluations performed on behalf of involuntary PSA clients may be shared with the districts pursuant to Section 33.13(d) MHL and the provisions of Sections 41.01 and 41.13 MHL which require mental health officials to cooperate with other public agencies, including local departments of social services.

2. In order to assure that appropriate evaluations are conducted, local district staff must provide mental health professionals with as much information as possible about their observations of a client's behavior, living situation and ability to make decisions. District staff also shall indicate to mental health professionals the specific legal interventions they are considering since the statutory criteria for utilizing the various forms of legal intervention are different.

3. If district staff are unable to obtain mental health evaluations, the local commissioner shall initiate efforts to resolve the problem through discussions with the director of community mental health services. If these efforts are unsuccessful, the local commissioner shall pursue the matter with the appropriate local government authorities, such as the County Executive or the Chairman of the Board of Supervisors. If these efforts fail, the local commissioner shall advise the Deputy Commissioner of the Division of Adult Services in writing of the problem and the efforts which were made to resolve it at the local level. Upon receipt of a letter from a local commissioner, the Deputy Commissioner of the Division of Adult Services will pursue the matter with appropriate representatives from State Office of Mental Health.

4. If a district is unable to obtain mental health evaluations on behalf of involuntary PSA clients through local mental health department, it must contract for the delivery of this service until the matter is resolved through the process described above. The cost of these evaluations shall be considered a Title XX PSA expenditure.

E. Districts must mark each PSA case file in which involuntary intervention has been pursued by the district, regardless of the outcome of the intervention. This will assure the prompt availability of these cases for review by Department staff.

V. Systems Implications

None

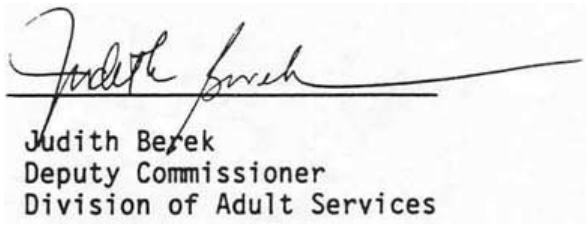
VI. Additional Information

As noted above, in considering involuntary intervention, it is important to distinguish between incapacity and incompetence. Incapacity means an inability to function in a given area. A person lacking capacity in one area can retain capacity and rights in other areas. Incompetence is a legal term which refers to a conclusion reached in a court of law that a person is incompetent to manage himself or his affairs. Incompetence means that the person lacks capacity in all areas. Most PSA clients who require involuntary interventions will be incapacitated, rather than incompetent.

Involuntary PSA clients are considered incapacitated if their inability to make decisions on their own behalf makes them unable to meet one or more of their essential needs or to protect themselves from harm, neglect or financial exploitation. As discussed above, districts must pursue the appropriate interventions on behalf of involuntary PSA clients who are believed to be incapacitated and, therefore, incapable of making decisions about certain areas of their lives.

VIII. Effective Date

June 1, 1988



Judith Berek
Deputy Commissioner
Division of Adult Services

-3808 (2/87)

87-ADM-006 Orders to Gain Access to Persons Believed to be in Need of Protection

NEW YORK STATE DEPARTMENT OF SOCIAL SERVICES

40 North Pearl Street

Albany, New York 12243

Cesar A. Perales, Commissioner

TRANSMITTAL:

DATE:

DIVISION:

TO:

SUBJECT:

SUGGESTED

DISTRIBUTION:

CONTACT PERSON:

88 ADM-023

May 23, 1988

Adult Services

Commissioners of Social Services

Protective Services For Adults: Serving Involuntary Clients

County and Agency Attorneys

Directors of Social Services

Protective Services for Adult Staff

Staff Development Coordinators

Any questions concerning this release should be directed to

the district's Protective Services for Adult Program

Representative at 1-800-342-3715 as follows:

Sharon Lane, ext. 432-2985

Kathleen Crowe, ext. 432-2996

Regina Driscoll, ext. 432-2864

Irv Abelman, ext. 432-2980 or (212) 804-1247.

FILING REFERENCES

Previous

ADMs/INFs

87 ADM-006

85 ADM-5

83 ADM-015

82 ADM-032

81 ADM-057

80 ADM-71

86 INF-11

84 INF-13

84 INF-008

79 INF-008

Releases

Cancelled

80 ADM-71

Dept. Regs.

Part 457

Soc. Serv.

Law & Other

Legal Ref.

Article 98 SSL

Mental Hygiene

Law

Family Court

Act

Public Health

Law

Surrogate's

Court Procedure

Act

Manual Ref. Misc. Ref.

Date May 23, 1988

Trans. No. 88 ADM-023 Page No. 2

I. Purpose

The purpose of this directive is to clarify the responsibility of local social services districts to provide involuntary services to Protective Services for Adults (PSA) clients under certain circumstances. This transmittal explains and amplifies the Department's regulations and provides guidance in the practical application of involuntary interventions.

II. Background

Although many persons in need of PSA accept services voluntarily, there are a number of involuntary clients who resist the provision of essential services. While local district PSA staff must respect an individual's right to self determination, they also have the legal responsibility to provide necessary services to persons who require them. Authority to protect the life and property of unwilling clients is established in Social Services Law, Mental Hygiene Law, the Fami1y Court Act, Public Health Law and the Surrogate's Court Procedure Act as well as in case law.

Since 1976, when information on the PSA program was first provided by the Department, districts have been reminded of their dual responsibility - protection of the client's rights and protection of the client from harm caused or threatened by reason of the client's incapacities. While the district may not impose a service on a client who is capable of self determination and self care, neither may the district walk away from the client who is threatened with harm, unable to make decisions on his behalf due to impairments and apparently unwilling to accept the needed services.

As part of the Department's PSA case review project to determine compliance with the PSA Process Standards as set forth in Part 457 of the Department's regulations and 85

ADM-5, we have noted that there is still considerable confusion among local staff regarding the responsibi1ity of districts to provide services to involuntary PSA clients. This directive is intended to provide needed clarification to local districts.

III. Program Implications

The information presented below amplifies Department policy, as set forth in applicable laws and regulation, regarding the delivery of services to involuntary PSA clients. This information should enhance the capability of district staff to serve involuntary PSA clients by providing them with a more thorough understanding of:

o the situations in which the district has a responsibility to provide services to involuntary PSA clients; and

o the legal interventions which are available to assist districts in the delivery of appropriate services to PSA clients.

Date May 23, 1988

Trans. No. 88 ADM-023 Page No. 3

A. GENERAL INFORMATION

PSA staff should give primary consideration to the individual rights of clients. To the fullest extent possible, clients should be supported by the caseworker in exercising free choice in making decisions, especially those which may involve significant changes in a client's life. A majority of individuals requiring PSA will become voluntary clients when informed of the services available to them. The establishment of trust and respect between worker and client, appropriate counseling and gentle persuasion will often help a resistive client accept services on a voluntary basis. The initial emphasis of the caseworker's efforts must generally be in this direction. PSA staff also must attempt to work with members of the client's family, friends and other persons of significance to the client, including staff of other agencies serving the client, to convince a resistant c1ient to accept services voluntarily.

It is not always possible to convince an endangered client to accept necessary services. Some clients may be so impaired that they are totally unable to comprehend their situation.

Other less impaired clients may be able to meet certain basic needs but unable to meet others. When, after a thorough assessment of a client's current situation, there is evidence of a serious threat to the safety and well being of the client and the client is incapable of making choices regarding the danger because of temporary or permanent impairment, the agency is obligated to secure services to ensure the client's safety, even if the client refuses them. Because the ability of the client to make decisions on his behalf is always a consideration when involuntary interventions are being considered, it is advisable to arrange for a mental health evaluation of the individual prior to pursuing any legal intervention.

In considering involuntary intervention, it is important to distinguish between incapacity and incompetence. Incapacity means an inability to function in a given area. A person lacking capacity in one area can retain capacity and rights in other areas. Incompetence is a legal term which refers to a conclusion reached in a court of law that a person is incompetent to manage himself or his affairs. Incompetence means that the person lacks capacity in all areas. Most PSA clients who require involuntary interventions will be incapacitated, rather than incompetent.

It is important that PSA staff have a basic understanding of the appropriate provisions of law and the practical legal issues they must face on a daily basis with their clients. It is equally important that a strong collaborative relationship be established with the professional legal staff assigned to the agency. If legal action is required, the agency attorney will be needed to prepare the case and present it before a judge, often on short notice. PSA staff must first identify the case as meeting the legal criteria for the appropriate form of intervention and recommend a course of action. The attorney must also be provided with documented evidence of the client's situation and need for the form of intervention recommended by the caseworker and his/her supervisor. A well prepared and well documented case generally results in a successful outcome in court. DSS-3808 (2/87)

The consequences of intervention contrary to the wishes or without the consent of a client

cannot be taken too seriously, and such action should be contemplated only after reasonable attempts have been made to secure the client's cooperation. If an involuntary intervention is being considered, the principle of "least restrictiveness" must be carefully observed at each step in the development of an involuntary plan of care. It must be emphasized that this does not mean that intervention is to be avoided. It does mean that each intervention must be limited in scope and include only those specific actions required to eliminate the existing endangering conditions and ensure the client's continued safety and well-being. If involuntary actions are required, to the extent possible, efforts should always be made to provide services in the client's own home with as little disruption to his chosen lifestyle as possible. There are, of course, circumstances in which a client's safety is seriously threatened in his current environment, and removal must be considered. If temporary removal from the client's home is required, every effort must be made to safeguard and maintain the house, and to return the adult to his home as soon as the conditions which necessitated removal are alleviated.

In some situations, it may not be possible to provide the services necessary to ensure the client's safety in his own home. If long term alternative living arrangements and residential placement are required, the client must be involved in the placement decision to the fullest extent possible consistent with his level of impairment. PSA staff should be actively involved in counseling the client and his family throughout the placement process. The district must make every effort to locate and provide advocacy in placing the client in the setting most appropriate for the client's needs.

There are two traditional legal principles, based in the Common Law, under which intervention may be pursued: the police power of the State, which gives the State authority to regulate activities that endanger the health and safety of other persons in society and the theory of parens patriae, which gives the State authority to act in a parental capacity for persons who cannot care for themselves or who are dangerous to themselves. These two principles provide a common law basis for the provision of PSA.

In addition to these common law underpinnings, the Social Services Law provides explicit statutory authority for PSA. Local social services districts are mandated by Section 473 of

the Social Services Law (SSL) to provide Protective Services for Adults. Services provided under PSA include: receiving and investigating reports of seriously impaired individuals who may be in need of protection; arranging for medical and psychiatric services; arranging for commitment, guardianship, conservatorship or other protective placement; cooperating and planning with the courts as necessary on behalf of individuals with serious mental impairments; and other specific protective services as set forth in the Consolidated Services Plan (CSP). Section 457.6 of the Department's regulations further states, "When the district believes that there is a serious threat to an adult's well-being and that the adult is incapable of making decisions on his or her own behalf because of mental impairments, the local social services official has a responsibility to pursue appropriate legal intervention ..." DSS-3808 (2/87)

Although local districts are mandated to provide PSA as noted above, additional authority to protect the life and property of unwilling clients is established in Mental Hygiene Law, the Family Court Act, Public Health Law and the Surrogate's Court Procedure Law, as well as Social Services Law. The immediacy and seriousness of the threat to the individual determine whether crisis intervention procedures and/or other legal procedures are warranted as set forth below. Districts have the authority as well as the responsibility to utilize these procedures in appropriate situations on behalf of involuntary PSA clients.

B. INVESTIGATING PSA REFERRALS

Local district staff sometimes encounter serious difficulties in investigating PSA referrals because they are unable to gain access to the potential client. Access is denied either by the subject of the PSA referral or by a family member or friend acting as the person's caregiver. Often the caregiver denying access to the potential client is suspected of abusing or exploiting this individual. In order to respond to these cases, local district staff enlist the assistance of family members, friends, neighbors or staff from other agencies already known to the potential client in order to gain access. However, there are still situations where local district staff cannot gain access. In those cases, staff are advised to request

assistance from law enforcement personnel. However, the ability and willingness of law enforcement personnel to effectively intervene vary greatly depending on the specific situation and the individual police jurisdiction involved. Section 473-c SSL addresses this problem by providing a mechanism for local districts, in conjunction with law enforcement personnel, to utilize in order to gain access to persons believed to be in need of PSA. Specific information regarding the steps to be taken to effectively utilize Section 473-c SSL may be found in 87 ADM-6.

C. CRISIS INTERVENTION

State law contains several specific interventions which can be utilized in crisis situations. For purposes of this directive, a crisis is defined as a situation in which there is an immediate and identifiable danger to a person or his property and the person, because of impairment, regardless of cause or duration, is incapable of making the choices necessary to remove the endangering condition.

1. Social Services Law (SSL): Short Term Involuntary Protective Services Orders (STIPSO)

Chapter 991 of the laws of 1981 established Section 473-a SSL, which authorizes local social services districts to petition a court for a STIPSO on behalf of certain PSA clients who are at imminent risk of death or serious physical harm and are unable to understand the consequences of their situation. This law was enacted in large part because PSA staff had often been unable to take the necessary immediate action to insure the safety of their clients, who, although unable to comprehend the seriousness of their situation, could not be admitted to a psychiatric facility

under Mental Hygiene Law (MHL) because their condition was not the result of mental illness. Because of the need for expeditious action, the provisions of MHL governing the appointment of conservators and committees were also of limited assistance due to the time consuming nature of these proceedings. Specific

information regarding procedures for implementing the STIPSO statute can be found in 81 ADM-57 and 82 ADM-32. Information regarding the utilization of STIPSO may be found in 86 INF-ll.

2. Mental Hygiene Law (MHL)

a. Involuntary Admission to a Psychiatric Facility

Section 9.47 of MHL provides that directors of community services, health officers and commissioners of social services have a duty to see that all mentally ill persons within their respective communities in need of care and treatment at a psychiatric hospital receive appropriate care. Therefore, the local district has a responsibility to obtain treatment for mentally ill individuals found in the community who are unable to function on their own, are acting in a manner likely to cause harm to themselves or others, and have no other responsible person or service provider available to provide the necessary help.

It is important that the concept of harm to oneself or others be understood within the context of Mental Hygiene Law. The "likelihood to result in serious harm" is defined in MHL to mean "a substantial risk of physical harm to himself as manifested by threats of or attempts at suicide or serious bodily harm or other conduct demonstrating that he is dangerous to himself," or "a substantial risk of physical harm to others as manifested by homicidal or other violent behavior by which others are placed in reasonable fear of serious physical harm" (Section 9.39 MHL).

The following actions must be initiated in appropriate situations by local districts on behalf of persons who appear to be "mentally ill" and "in need of treatment" and whose behavior can be documented to indicate a "likelihood to result in harm" to themselves or others.

1) Enlist the Immediate Assistance of a Peace Officer (Section 9.41MHL)

Any peace officer of the state, town, village, county or city who is a member of the State Police or of an authorized police department or force or of a sheriff’s department may take into custody any person who appears to be

mentally ill and is conducting himself in a manner which is likely to result in serious harm to himself or others. The officer may direct the removal of such person or remove him to a hospital with appropriate staff and facilities to care for mentally ill persons. (It is important to emphasize that the decision to admit an individual to a psychiatric facility rests with the facility.) DSS-3808 (2/87)

2) Request Action by the Local Director of Community Services (Sections 9.37and 9.45 MHL)

The director of community services, usually the county Mental Health Commissioner or his official designee, has the authority to examine and remove a mentally ill person to a psychiatric facility for treatment and care. In addition, the director has the authority to direct any state, county or local peace officer to transport the individual to the facility when required. (However, the decision to admit the person to the facility rests with the facility.)

3) Initiate Application for Admission to a Mental Facility on Certification of Two Physicians (Section 9.27 MHL)

A social services official is authorized to initiate the application for admission to a psychiatric facility on behalf of a mentally ill individual who needs involuntary care. The application must contain a statement of the facts upon which the allegation of mental illness and need for involuntary care is based. The application must be accompanied by the certificates of two examining physicians. (Again, it must be emphasized that the decision to admit the individual to a psychiatric facility rests with the facility.)

b. Admission of Involuntary or Non-Objecting Persons to a Developmental Center

A separate section of MHL gives certain public officials, including commissioners of social services, explicit authority to initiate applications for admission to developmental centers on behalf of mentally retarded individuals. The local districts

must initiate the following actions on behalf of persons alleged to be mentally retarded and in need of involuntary care and treatment.

1) Involuntary Application for Admission to a Developmental Center on Medical Certification (Section l5.27 MHL)

A social services official is authorized to initiate an application for admission to a developmental center on behalf of an individual who is alleged to be mentally retarded and in need of involuntary care and treatment. The application must contain a statement of facts upon which the allegation of mental retardation and need for involuntary care and treatment are based and must be accompanied by the certificates of two examining physicians or of one examining physician and one certified psychologist. (The final decision to admit the individual to a developmental center rests with the facility.)

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2) Application for Admission to a Developmental Center on Behalf of Certain Non-Objecting Adults (Section 15.25 MHL)

A social services official is authorized to initiate an application for admission to a developmental center on behalf of an individual in need of care and treatment who does not object but who is so profoundly or severely retarded that he does not have sufficient understanding to give informed consent. The application must conform to the requirements set forth in Section 15.27 MHL (discussed above) and must be accompanied by the certificate of one examining physician or certified psychologist.

c. Temporary Restraining Order to Protect the Property and Welfare Of a Proposed Conservatee (Section 77.O8 MHL)

Chapter 489 of the Laws of 1982 amended Article 77 MHL to expand the powers of the court to provide provisional remedies which offer immediate protection of the property and welfare of a proposed conservatee pending the appointment of a

conservator. Under the provisions of Section 77.08 MHL, a petition may be made in county or supreme court, upon a showing of good cause, for the issuance of a temporary restraining order preventing any specified person from affecting the property of the proposed conservatee, or from committing an act or allowing an act of omission which could be shown to endanger the welfare of the proposed conservatee. In addition, the law empowers the court to give any such temporary restraining order the effect of a restraining notice to persons having custody or control over the person or property of the proposed conservatee, thereby prohibiting the sale, assignment, transfer or interference with any property of the proposed conservatee, except pursuant to court order.

This statute provides the districts with an effective tool in situations in which a PSA client is unable to protect himself or his property from the neglectful or exploitive actions of another person and prompt action is required to protect the client from further harm. This action must follow a formal petition for conservatorship. Conservatorship proceedings are discussed in greater detail below.

3. Family Court Act (FCA): Orders of Protection

Article 8 of the Family Court Act (FCA) may be utilized to obtain orders of protection on behalf of adults who are victims of abusive or neglectful acts by a child or other member of the family or household. Petitioning a court for an order of protection is a civil proceeding. It provides an alternative to criminal prosecution of the abusive family member or other actions taken on behalf of the abused PSA client which often may result in their removal from the home.

At a minimum, a petition to Family Court for an order of protection must contain an allegation that the accused abuser has committed acts which would constitute disorderly conduct, harassment, menacing, reckless endangerment or assault in the second or third degree, and a statement of the relationship of the alleged offender to

the petitioner (Section 821 FCA). Examples of these actions include physical abuse and preventing or interfering with the delivery of essential services and care, including hospitalization and residential care. Whenever possible, abused persons should be encouraged to file for an order of protection on their own behalf. The Family Court Act, however, also authorizes local public welfare officials and representatives of other duly authorized agencies to initiate proceedings for orders of protection (Sections 119 and 822 FCA). The Family Court does not require physical or mental impairment as a prerequisite for issuance of an order of protection on behalf of an adult for whom a third party has initiated a petition. However, it is recommended that districts include any available documentation regarding the client's impairment and inability to protect himself.

Following the filing of a petition, a Family Court may, upon a showing of good cause, issue an immediate temporary order of protection. A temporary order can provide the protection requested before the matter has been fully investigated and decided. It may set forth any "reasonable conditions of behavior" to be observed by the respondent or any other family or household member. Often a situation may be resolved following the issuance of a temporary order of protection with no further court action required. (Section 828 FCA)

Following a hearing and based on a finding that the allegations are "supported by a fair preponderance of the evidence", the Family Court may issue a permanent order of protection, which may remain in effect for up to one year. (Section 842 FCA)

4. Public Health Law (PHL): Situations Where There Is A Danger to the Public Health and Safety

In those situations where the physical health and safety of the client or others is put in jeopardy because of dangerous or unsanitary living conditions, districts should enlist the help and cooperation of local public health officials. Such officials are authorized to investigate complaints of unsanitary or unsafe conditions affecting the public health. It is within their scope of responsibility to cite violations and, if the violations are not removed, file appropriate charges which are subject to fine or

imprisonment. Public health officials, upon failure of a property owner to comply with a duly executed order, may enter a premises and remove and/or suppress any condition which is determined to be "detrimental to the public health." In most situations, the official citation of violations may be sufficient to stimulate corrective action or the client's acceptance of services (Sections 1303-1305, 1308,2120 PHL).

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5. Parens Patriae: Court Orders to Obtain Medical Treatment

Under the common law principle of "parens patriae", which is discussed above, the State Supreme Court has the authority to issue orders for medical treatment on behalf of certain seriously impaired adults who are unable to act for themselves. Case law gives the court authority to appoint guardians and receivers to protect the interests of disabled adults or to give consent for medical treatment. Courts engage in a case by case review of the specific facts presented. Examples of case law include Weberlist, 360 NYS 2d 783 (Sup. Ct., NYC, 1974); New York City Health and Hospital Cor. v. Stein, 335 NYS 2d 461 (Sup. Ct., NYC, 972; Matter of Roosevelt Hospital NYLJ Jan. 13, 1977 (Sup. Ct., NYC); and Matter of Storar, 438 NYS 2d 266 (1981), cert. den. 454 U.S. 858 (1982).

Courts may, under other statutes, appoint a conservator (Article 77 MHL), committee (Article 78 MHL) and Guardian for the Mentally Retarded (Article 17-A, Surrogate's Court Procedure Act) and authorize that person, under court supervision, to make certain specified medical decisions. Courts, however, do not have the authority to authorize intrusive medical procedures with a STIPSO under Section 473-a SSL.

Local district staff are responsible, where appropriate, for arranging for medical services for PSA clients. This is usually accomplished through referral to other appropriate agencies. However, situations do arise in which a PSA client urgently requires a specific medical intervention, such as surgery, and is unable, due to

mental and/or physical impairments, to make an informed decision to proceed with the needed treatment and does not have a court appointed surrogate. In these circumstances, it may be necessary for the district to be involved in pursuing a court order to obtain medical treatment. It should be noted that neither an adult child, the parent of an adult child nor a local social services official may lawfully make substitute decisions regarding medical treatment on behalf of another adult without first obtaining a specific court order except in certain limited instances involving psychiatric inpatients.

Careful consideration is necessary when determining whether to seek a court order to impose medical treatment against the wishes of an impaired adult. Even with a non-resistant adult who is considered too impaired to provide "informed consent", a court order must be sought to provide medical treatment. Under all circumstances, medical intervention should be limited to the least restrictive appropriate measure.

In certain emergency situations in which consent is not "reasonably possible", such as in the case of a seriously mentally disabled individual who needs emergency surgery, it is legally defensible for a hospital to provide treatment in the absence of the patient's informed consent (Section 2805-d PHL).

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D. LEGAL PROCEDURES OF LONG TERM CONSEQUENCES

The following legal interventions involve the use of court procedures which provide for long term management of the property or the property and person of impaired individuals by court appointed surrogates. These procedures require more time to implement than is afforded in emergency or crisis situations. They are to be initiated only for persons who have demonstrated such a degree of incapacity that supportive services alone are not adequate to achieve a plan of protection. These procedures are set forth in Articles 77 and 78 of MHL and Article 17-A of the Surrogate's Court Procedure Act, which govern the appointment of conservators, committees and guardians for the mentally retarded.

Conservatorship and committee proceedings are initiated in the Supreme Court or County Court, while guardianship for the mentally retarded proceedings are initiated in the Surrogate's Court. A discussion of the Community Guardian Program follows a discussion of the above-noted procedures.

1. Conservator

Article 77 of MHL sets forth the procedures for the designation of a conservator for the property of a person who has not been declared to be incompetent by a court but who "by reason of advanced age, illness, infirmity, mental weakness, alcohol abuse, addiction to drugs, or other cause, has suffered impairment of his ability to care for his property or has become unable to provide for himself or others dependent upon him for support." Any "friend" of the proposed conservatee, including a relative, a corporate body, a public agency or a social services official may initiate a conservatorship proceeding and act as a conservator.

The primary duties of a conservator are to preserve, maintain and care for the proposed conservatee's income and assets. The court must, however, approve a plan for the conservator to provide for the conservatee's well-being, including the provision of necessary personal and social protective services to the conservatee. Therefore, the court may grant additional powers to a conservator, including control over personal care and placement decisions, which are specified in the court order. Although several conservatorship orders have given the conservator the authority to make placement decisions, not all courts are willing to do so.

The following proof/documentation regarding the proposed conservatee must be presented to the court:

- the reason for concern for the financial and personal well-being of the individual;
- clear and convincing proof of the need for a conservator, including proof of functional impairment (an assessment by a mental health professional is not required by law, but may be required by the judge);

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- the name and address of the proposed conservatee, his spouse, his legal heirs and the person or agency, if any, currently having custody of his person;
- the nature, probable value and income of all property;
- the anticipated duration of the conservatorship, and if indefinite, why a fixed period is not more appropriate;
- the extent of income and assets to be placed under the conservatorship and the necessity for so doing; and
- the petitioner's proposed plan to insure the preservation, maintenance and care of the proposed conservatee's income, assets and personal well-being, including the provision of necessary personal and social protective services to the conservatee.

The local social services district must first determine if there is another interested and responsible person or agency to file the petition and act as conservator on behalf of a PSA client. If no one else is willing or capable of acting in this capacity, the district must apply for conservatorship as required by Section 457.1(c)(9) of the Department's regulations.

A notice of the conservatorship petition must be served on the proposed conservatee, his spouse and children, or if none are known, his legal heirs, or if none are known, the person with whom he resides or the director of the facility in which he resides. The court may appoint a guardian ad litem to represent the interest of the proposed conservatee. The guardian must fully investigate the situation and arrive at a finding for presentation to the court. A hearing will take place before the judge unless the court determines that a trial by jury is appropriate, for reasons stated in the law. Local districts must act as a conservator for a PSA client if no one else is willing and capable of acting in this capacity. An annual accounting and inventory must be filed with the court every January. If the district is named conservator, the client's estate must be managed in accordance with the requirements set forth in 83 ADM-15 and

briefly discussed in the following section entitled Financial Management Procedures.

Article 77 MHL contains a provision for a temporary restraining order to protect the property and welfare of a proposed conservatee when there is a need for prompt intervention. This is described in greater detail in Section B.2.c. above.

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2. Committee

Article 78 of Mental Hygiene Law sets forth the procedures for the appointment of a committee for a person who is incompetent to manage himself or his affairs. Anyone may commence a special proceeding to declare a person incompetent and to appoint a committee of an incompetent. Where the property of any person is endangered by reason of his incompetence and no proceeding has been commenced, the local social services commissioner is required to bring the proceeding (Section 78.03 MHL).

The essential element in the establishment of a committee is the finding by the court that the adult is legally incompetent. This results in a substantial reduction in personal civil rights. It is not a procedure to be pursued for persons who are only partially or sporadically impaired in their functioning and are capable of retaining some independence. The totality of both the disability of the affected person and the duties and powers of the committee, albeit subject to the supervision of the court, are strong reasons why a committee proceeding should only be considered when it is clear that an adult is severely and permanently impaired and no less restrictive measures would suffice. Additionally, Section 78.02 MHL requires that, prior to the appointment of a committee, the court must first consider whether the interests of the individual could best be served by the appointment of a conservator.

The procedure to be followed in the establishment of a committee is basically the same as that for a conservatorship (discussed above).

3. Guardianship for the Mentally Retarded

Article l7-A of the Surrogate's Court Procedure Act established a procedure for the protection of persons who are mentally retarded. The law provides for the appointment of a guardian for a mentally retarded person who is certified as incapable of managing himself and/or his affairs because of permanent mental retardation. The certification must be made by at least two licensed physicians, or a licensed physician and a certified psychologist. The guardian may be appointed over the person, the property or both. Parents, relatives or other interested persons may be appointed as guardian. A non-profit corporation may be appointed as corporate guardian of the person only. A standby guardian may be appointed by the court to assume guardianship upon the death of the guardians/parents.

Because case management responsibility for individuals who have been formally diagnosed as mentally retarded is generally assumed by other agencies, local social services districts probably will have limited involvement in this area. However, in accordance

with Section 473.l(c) and (e), SSL and Section 457.l(c)(7) of the Department's regulations, local districts must petition for the appointment of a guardian of the mentally retarded in appropriate situations where no one else is willing and able to act on behalf of the client. The process and information to be presented to the court is similar to that for conservatorship and committee, with the exception of the need to present a certification of mental retardation. The agency attorney should be consulted immediately if it appears necessary for the district to pursue guardianship.

4. Community Guardian Program

Section 473-c SSL established a Community Guardian Program which allows a social services official to contract with a non-profit organization or government agency to serve as conservator or committee for PSA clients. Under provisions of this statute, the local social service official may bring a petition to appoint a conservator or committee under Article 77 or 78 MHL for a person who is:

o eligible for and receiving PSA;

o living outside a hospital or residential facility or able to return to the community if a conservator or committee is appointed; and

o without capable friend, relative or agency willing to serve as conservator.

Upon being appointed conservator or committee, the Community Guardian Program must:

o make best efforts to maintain the person in the community;

o obtain medical, social, mental health, legal and other services that are available and required for the person's safety or well-being;

o advocate for all entitlements, public benefits and services for which the person qualifies and which the person requires; and

o obtain an annual assessment from two qualified psychiatrists or a qualified psychiatrist and a qualified psychologist to determine if services are still required.

Additional information regarding the Community Guardian Program may be found in Section 457.12 of the Department's regulations.

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E. FINANCIAL MANAGEMENT

Many PSA clients will have limited or no ability to manage day-to-day financial transactions and/or protect themselves from exploitation. Sometimes financial management is the client's primary need. A client's inability to manage his finances may result in failure to pay essential bills, wasting of resources, and/or failure to purchase adequate food, clothing, shelter or medical care. This inability may also leave them vulnerable to exploitation by others, which can include unauthorized use of a client's telephone or property, theft of food or household possessions, unauthorized withdrawals from bank accounts, and refusal to purchase essential goods and services by a caregiver who controls the client's funds.

In accordance with the requirements of Section 473 SSL and Part 457 of the Department's regulations, districts must be prepared to provide certain financial management services to their PSA clients. Section 457.l(c)(4) of the Department's regulations requires local districts to provide counseling to PSA clients and their families, which includes advice regarding the use of the client's funds. Section 457.l(c)(9) requires the districts to function as conservator, representative payee or protective payee when these services are determined to be necessary and no other individual or agency is willing and capable of providing them.

The Social Security Administration can designate a representative payee to receive cash benefits on behalf of a beneficiary receiving either OASDI or SSI benefits when there is positive legal, medical or other acceptable evidence presented which establishes that the beneficiary is unable to manage his assets or protect his interests by reason of physical or mental impairment. Other retirement systems have established procedures similar to those of the Social Security Administration for appointing fiduciaries on behalf of beneficiaries who are unable to manage their benefits. The Railroad Retirement System uses the term "representative payee" and the Veterans Administration uses the term "fiduciary" or "custodian". When it becomes apparent that a PSA client is in need of the appointment of a representative payee (or fiduciary or custodian), every effort should be made to involve a legal guardian, relative or friend as the representative payee. If no responsible person can be found to act in this capacity, the local district commissioner must apply to be designated as representative payee.

Part 381 of the Department's regulations includes procedures designed to address the needs of clients who by reason of mental or physical incapacity are unable to manage their public assistance grants. One mechanism involves protective payments, i.e. the issuance of the client's ADC or HR grant to an individual other than the recipient when the client has demonstrated an inability to manage funds. This payment may be made to a staff member of the local social services district, preferably staff providing protective services.

Additional information regarding financial management services and the Department's requirements for a written financial management system may be found in 83 ADM-15, 84 INF-8 and 79 INF-8.

F. IMMUNITY FROM CIVIL LIABILITY

Local social services staff often have concerns regarding the potential liability of the agency and themselves in civil lawsuits initiated on behalf of PSA clients. While these issues are generally of greatest concern in the context of providing services to seriously at risk involuntary clients, they also pertain to voluntary clients. Laws providing immunity from civil liability for local district PSA staff and individuals who make good faith reports of persons in need of PSA are discussed below. Additionally, it should be noted that districts are usually more liable for not acting on behalf of an impaired adult than for taking actions they deem appropriate.

1. Immunity of Public Officials

Section 473.3 SSL provides explicit immunity from civil liability for any social services official or his designee involved in the provision of PSA. This subdivision of the law reads as follows:

"Any social services official or his designee authorized or required to determine the need for and/or provide or arrange for the provision of protective services to adults in accordance with the provision of this section, shall have immunity from any civil liability that might otherwise result by reason of providing such services, provided such official or his designee was acting in the discharge of his duties and within the scope of his employment, and that such liability did not result from the willful act or gross negligence of such official or his designee."

Although this law provides immunity from civil liability for PSA staff acting in the discharge of their duties and within the scope of their employment, it does not

prevent them from being sued. The law does, however, provide PSA staff and the local districts with a strong legal defense for responding to such lawsuits.

2. Immunity for Persons Who Report Endangered Adults or Persons in Need of Protective Services

Chapter 523 of the Laws of 1984 established Section 473-b SSL, which provides immunity from any civil liability to persons who in good faith believe that an adult may be endangered or in need of protective services, and who report or refer such person to the Department, the State Office for the Aging, any local social services district, area agency on aging, law enforcement agency, or any other person, agency or organization that the reporters believe, in good faith, will take appropriate action. The immunity provision also extends to persons who testify in any judicial or administrative proceeding which results from a report or referral. DSS-3808 (2/87)

Immunity from civil liability may encourage referral sources and other persons whose testimony may be necessary in a judicial or administrative proceeding to disclose more information to local district staff during the course of PSA investigations. As with the immunity law for PSA staff, this law is not a guarantee against lawsuits. It does, however, provide a strong legal defense for responding to such lawsuits. Local districts should make other local agencies and referral sources aware of this statute. Additional information regarding immunity for reporters may be found in 84 INF-13.

IV. Required Action

A. Local commissioners must assure that a procedure is in place which ensures the availability of the local agency's legal staff for prompt consultation with PSA staff when requested and timely implementation of legal interventions on behalf of PSA clients in appropriate situations. This procedure must assure that in those situations where there is a disagreement between services and legal staff about the appropriateness of a legal intervention on behalf of a PSA client, the matter will be promptly referred to the local

commissioner or his designee, who wi1l make the decision on whether to pursue legal action.

B. PSA and legal staff must familiarize themselves with the range of interventions set forth in this directive which can be utilized on behalf of involuntary PSA clients and the situations in which each of these interventions can be appropriately employed on behalf of the client.

C. Since involuntary interventions will often require the involvement of other agencies, local districts must continue their community education/networking activities in accordance with Section 457.7 of the Department's regulations, including meetings with representative community agencies for the purpose of establishing specific agency roles and areas of responsibility in the provision of PSA.

D.1. As noted above, when involuntary interventions are being considered, it is advisable to arrange for a mental health evaluation of the client. Usually, such an evaluation is conducted in the client's home by a qualified menta1 health professional. The State Office of Mental Health (OMH) has indicated that local mental health departments, in accordance with their service planning and delivery responsibilities set forth in Section 41.01 and 41.13 of the Mental Hygiene Law (MHL), are responsible for providing or arranging for the provision of mental health evaluations by qualified personnel on behalf of involuntary PSA clients when the district is contemplating legal intervention. Therefore, local districts must establish a process to obtain such evaluations through the local mental health department. Depending on the service delivery structure of a given locality, these evaluations should be provided either by the mental health department, a voluntary agency under contract with the mental health department, or the State Psychiatric Facility serving that

geographic region. The State Office of Mental Health also has advised us that mental health evaluations performed on behalf of involuntary PSA clients may be shared with the districts pursuant to Section 33.13(d) MHL and the provisions of Sections 41.01 and 41.13

MHL which require mental health officials to cooperate with other public agencies, including local departments of social services.

2. In order to assure that appropriate evaluations are conducted, local district staff must provide mental health professionals with as much information as possible about their observations of a client's behavior, living situation and ability to make decisions. District staff also shall indicate to mental health professionals the specific legal interventions they are considering since the statutory criteria for utilizing the various forms of legal intervention are different.

3. If district staff are unable to obtain mental health evaluations, the local commissioner shall initiate efforts to resolve the problem through discussions with the director of community mental health services. If these efforts are unsuccessful, the local commissioner shall pursue the matter with the appropriate local government authorities, such as the County Executive or the Chairman of the Board of Supervisors. If these efforts fail, the local commissioner shall advise the Deputy Commissioner of the Division of Adult Services in writing of the problem and the efforts which were made to resolve it at the local level. Upon receipt of a letter from a local commissioner, the Deputy Commissioner of the Division of Adult Services will pursue the matter with appropriate representatives from State Office of Mental Health.

4. If a district is unable to obtain mental health evaluations on behalf of involuntary PSA clients through local mental health department, it must contract for the delivery of this service until the matter is resolved through the process described above. The cost of these evaluations shall be considered a Title XX PSA expenditure.

E. Districts must mark each PSA case file in which involuntary intervention has been pursued by the district, regardless of the outcome of the intervention. This will assure the prompt availability of these cases for review by Department staff.

V. Systems Implications

None

VI. Additional Information

As noted above, in considering involuntary intervention, it is important to distinguish

between incapacity and incompetence. Incapacity means an inability to function in a given area. A person lacking capacity in one area can retain capacity and rights in other

areas. Incompetence is a legal term which refers to a conclusion reached in a court of law that a person is incompetent to manage himself or his affairs. Incompetence means that the person lacks capacity in all areas. Most PSA clients who require involuntary interventions will be incapacitated, rather than incompetent.

Involuntary PSA clients are considered incapacitated if their inability to make decisions on their own behalf makes them unable to meet one or more of their essential needs or to protect themselves from harm, neglect or financial exploitation. As discussed above, districts must pursue the appropriate interventions on behalf of involuntary PSA clients who are believed to be incapacitated , and, therefore, incapable of making decisions about certain areas of their lives.

VIII. Effective Date

June 1, 1988

12-OCFS ADM-05- clarifies the procedure under Social Services Law 473-c for Protective Services for Adults caseworkers who are refused access to a person believed to be in need of protective services.

NEW YORK STATE
OFFICE OF CHILDREN & FAMILY SERVICES

Andrew M. Cuomo
Governor

52 WASHINGTON STREET
RENSSELAER, NY 12144

Gladys Carrión, Esq.
Commissioner

Administrative Directive

Transmittal:	12-OCFS-ADM-05
To:	Commissioners of Social Services
Issuing Division/Office:	Division of Child Welfare and Community Services
Date:	May 24, 2012
Subject:	**Protective Services for Adults (PSA): Chapter 412 of the Laws of 2011**
Suggested Distribution:	Directors of Social Services PSA Supervisors and Staff Agency Attorneys
Contact Person(s):	Bureau of Adult Services Director, Alan Lawitz: Alan.Lawitz@ocfs.state.ny.us or 518 474-9431, or your district's Adult Services Program representative: Deborah Greenfield: Deborah.Greenfield@ocfs.state.ny.us or 518 402-3895 Paula Vielkind: Paula.Vielkind@ocfs.state.ny.us or 518 474-9590 Michael Cahill: Michael.Cahill@ocfs.state.ny.us or 518 486-3430 Lisl Maloney: Lisl.Maloney@ocfs.state.ny.us or 518 474-9445
Attachments:	Attachment A: Chapter 412 of the Laws of 2011
Attachment Available Online:	Yes, at http://public.leginfo.state.ny.us/menugetf.cgi

Filing References

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
87 ADM 6 93 ADM 23		18 NYCRR 457.11	SSL section 473-c		

I. Purpose

The purpose of this release is to advise local social services districts (districts) of the steps that must be taken to implement the provisions of Chapter 412 of the Laws of 2011, which clarifies the procedure under Social Services Law (SSL) section 473-c for Protective Services for Adults caseworkers who are refused access to a person believed to be in need of protective services. Chapter 412 of the Laws of 2011 requires that caseworkers who are refused access to such a person obtain a supervisory consultation within 24 hours after a refusal of access, and assess whether to apply for an order to gain access to the person believed to be in need of protective services.

II. Background

SSL section 473-c, enacted by Chapter 413 of the Laws of 1986, authorizes districts to petition the court for an order to gain access in order to assess a person's need for Protective Services for Adults (PSA), when the district has reasonable cause to believe that services are necessary and the district is refused access by that person or another individual.

Chapter 412 of the Laws of 2011 amends SSL section 473-c to require that the PSA caseworker, upon a refusal of access, shall assess, in consultation with a person in a supervisory role, whether or not it is appropriate to apply for an order to gain access to such person. This assessment must be made as soon as necessary under the circumstances, but no later than twenty-four hours after access is refused. The determination and the reasons for that determination must be documented in the file. A copy of this chapter law is attached as Attachment A.

The 2011 amendment to SSL Section 473-c incorporates the existing regulatory standards into the law and expands upon them to require that supervisory consultation and an assessment occur within 24 hours after a refusal of access. Chapter 412 took effect immediately upon enactment.

III. Program Implications

Chapter 412 of the Laws of 2011 requires that once there has been a refusal of access to a person believed to be in need of PSA, either by the person believed to be in need of PSA or by someone else:

a) the PSA worker must consult with a supervisor to assess whether it is appropriate to petition for an order to gain access;
b) such consultation must occur as soon as necessary under the circumstances, but no later than 24 hours after the refusal of access; and

c) the determination of whether or not to apply for an order to gain access and the reasons for that determination must be documented in the PSA case file.

Not every situation in which the PSA caseworker fails to gain access will trigger the need for a supervisory consult within 24 hours. For example, situations such as an attempted home visit when no one is at home, or when no one is answering the door bell or the knock on the door, and it does not appear that someone is home and deliberately seeking to avoid contact with the PSA worker, do not trigger the need for a supervisory consult within 24 hours.

Chapter 412 of the Laws of 2011 does not create a new requirement that the district petition for an access order within a certain time frame, or that the district petition at all. Chapter
412 of the Laws of 2011 does not specify the form of the supervisory consultation that must
occur after the refusal of access. Such consultation may be in person, or by telephone, so long as there is sufficient opportunity for the PSA worker and the supervisor to discuss the pertinent details of the case, including, but not limited to:

- Information received from the referral source;
- Collateral contact information received by the PSA worker;
- The attempt(s) made to obtain access to the person believed to be in need of PSA;
- Whether it is currently believed that the person may be in need of PSA;
- Whether it is believed that the district should seek to apply <u>at this time</u> for an order to gain access, and if so, the reason for that determination.

Such consultation should <u>not</u> occur by e-mail exchange only. It is acceptable for the PSA worker and the supervisor to exchange e-mail or other written communication about the refusal of access that occurred and the circumstances of the case, but in order to have a meaningful consultation there must be an actual conversation between the PSA worker and the supervisor concerning the above-stated information about the case.

Since Chapter 412 of the Laws of 2011 requires that the assessment of whether or not it is appropriate to apply for an order to gain access, in consultation with the supervisor, must be made as soon as necessary under the circumstances, but no later than 24 hours after the refusal of access, each district will need to make arrangements to have necessary PSA casework and supervisory staff available to make such assessments within this prescribed timeframe. This may require that consultations occur after normal office hours. Additionally, it may be necessary for PSA staff to consult with agency counsel to determine whether it is appropriate at that point to apply for an order to gain access. Districts will therefore also need to arrange to have agency counsel available to assist PSA staff in making the determination whether it is appropriate at that point to apply for an order to gain access.

Chapter 412 of the Laws of 2011 states that such assessments shall be made "as soon as necessary under the circumstances." The statute, regulations and past administrative directives provide guidance as to what actions are necessary in order to determine whether and when to make an application for an order to gain access at a given point in time.

The statute requires the district to state in any petition for an order to gain access "the efforts made by the social services official to gain access to the person who may be in need of protective services for adults" [SSL section 473-c (1)(d)]. This language contemplates that the PSA worker will be making efforts to obtain access to an adult who may be in need of PSA, and that such efforts will be documented in the case record.

Existing regulations at 18 NYCRR section 457.11(b) require a PSA worker who is denied access to a person who is believed to be in need of PSA to take the following actions:

> 1) enlist the aid of family members, friends, neighbors or staff of other appropriate agencies, including law enforcement agencies, for the purpose of persuading the individual(s) responsible for denying access to permit the district to complete an assessment of the person's need for PSA; and
>
> 2) if the efforts initiated in accordance with paragraph (1) of this subdivision are unsuccessful, the social services district must determine whether or not to apply to the Supreme Court or the County Court for an order to gain access to a person who may be in need of PSA. In deciding whether or not to apply for such an order, the social services district must determine if the information provided by the referral source and other persons familiar with the situation and the observations of staff of the social services district warrant such an action.

Please note that guidance provided in 87 ADM 6 and 93 ADM 23 concerning action to be taken when access is denied should be reviewed as well.

Chapter 412 of the Laws of 2011 requires that "the determination of whether or not to apply for an order to gain access and the reasons therefor shall be documented in the investigation file." PSA workers should document this information in the progress notes, or reference in the progress notes the inclusion of such documentation in the case record. Regulations require that progress notes be recorded in the PSA case record as soon as possible but no later than 30 days after the date of the event which required use of progress notes [18 NYCRR Section 457.2(c)].

IV. Required Action

Steps to be taken by the district to implement Chapter 412:

1. Consultation with Supervisor After Refusal of Access

A PSA worker who is refused access to an adult believed to be in need of PSA shall assess, in consultation with a person in a supervisory role, whether or not it is appropriate to apply for an order to gain access to such person.

2. Consultation within 24 Hours After Refusal of Access

Such assessment must be made as soon as necessary under the circumstances but no later than 24 hours after the PSA worker is refused access. Districts will need to make arrangements to have necessary PSA casework and supervisory staff -- and in some cases, agency counsel -- available to make such determinations within the 24-hour time frame, even if this means that such consultations occur after normal office hours.

3. Determinations and Reasons For Determinations Must Be Documented

The determination whether or not to apply for an order to gain access at that point in time and the reasons for the determination must be documented in the PSA case record.

/s/ Laura M. Velez

Issued By:
Name: Laura M. Velez
Title: Deputy Commissioner
Division: Child Welfare and Community Services

Attachment A

Laws of New York, 2011

CHAPTER 412

AN ACT to amend the social services law, in relation to an order to gain access to persons believed to be in need of protective services for adults

Became a law August 17, 2011, with the approval of the Governor. Passed by a majority vote, three-fifths being present.

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

Section 1. The opening paragraph of subdivision 1 of section 473-c of the social services law, as added by chapter 413 of the laws of 1986, is amended to read as follows:

A social services official may apply to the supreme court or county court for an order to gain access to a person to assess whether such person is in need of protective services for adults in accordance with the provisions of section four hundred seventy-three of this article when such official, having reasonable cause to believe that such person may be in need of protective services, is refused access by such person or another individual. **A social**

services official who is refused access shall assess, in consultation with a person in a supervisory role, whether or not it is appropriate to apply for an order to gain access to such person. Such assessment must be made as soon as necessary under the circumstances, but no later than twenty-four hours after the investigating official is refused access. The determination of whether or not to apply for an order to gain access and the reasons therefor shall be documented in the investigation file. Such application **for an order to gain access** shall state, insofar as the facts can be ascertained with reasonable diligence:

§ 2. This act shall take effect immediately.

The Legislature of the STATE OF NEW YORK **ss:**

Pursuant to the authority vested in us by section 70-b of the Public Officers Law, we hereby jointly certify that this slip copy of this session law was printed under our direction and, in accordance with such section, is entitled to be read into evidence.

DEAN G. SKELOS
Temporary President of the Senate

SHELDON SILVER
Speaker of the Assembly

EXPLANATION--Matter in ***italics*** is new; matter in brackets [–] is old law to be omitted.

INFORMATIONAL LETTER	TRANSMITTAL: 95 INF-20
	DIVISION: Services & Community Development & Housing & Adult Services
TO: Commissioners of Social Services	
	DATE: June 23, 1995

SUBJECT: The Family Protection and Domestic Violence Intervention Act

SUGGESTED DISTRIBUTION:
Directors of Services
Child Welfare Staff
Adult Services Staff
Directors of Income Maintenance
Domestic Violence Services Providers
Agency Attorneys
Staff Development Coordinators

CONTACT PERSON: Services & Community Development:
Regional Office Director:
Albany: Bill McLaughlin, 518-432-2751/ID 0FN010
Buffalo: Linda Brown, 716-847-3145/ID 89D421
Metropolitan: Anona Joseph, 212-383-1788/ID 0FF010
Rochester: Linda Kurtz, 716-238-8201/ID 0FH010
Syracuse: Jack Klump, 315-423-1200/ID 89W005
Housing & Adult Services, Representative:
Irv Abelman, 212 383-1755, USERID 0AM020
Tom Burton, 518 432-2987, USERID AX2510
Kathleen Crowe, 518 432-2985, USERID ROF017
Michael Monahan, 518 432-2667, USERID AY3860
Janet Morrissey, 518 432-2864, USERID 0PM100

ATTACHMENTS: None

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
94 ADM-11		Parts 452,	Article 6-A-		91 LCM-149
95 ADM-2		453, 454,	SSL		92 LCM-6
95 INF-10		455, 408, 462	131-u-SSL		94 LCM-153

DSS-329EL (Rev. 9/89) This release is to inform you of the key provisions of The Family Protection and Domestic Violence Intervention Act of 1994. This comprehensive legislation includes major revisions to the Family Court Act (FCA) and the Criminal Procedure Law (CPL) providing for more aggressive law enforcement and criminal justice interventions and protections for victims of domestic violence. The Act addresses the following major areas: choice of forum, mandatory arrest, orders of protection, and training. With the exception of the mandatory arrest provisions, this law is effective January 1, 1995. The mandatory arrest provisions are effective July 1, 1995. A number of the major provisions of this Act are highlighted below. I. Overview of Major Provisions of the Law

1. A key provision of the Act eliminates the three-day "choice of forum" rule which precluded victims of family violence from securing access to both family and criminal courts. By adding a new subdivision (e) to Section 115 of the FCA, the new law establishes concurrent family court and criminal court jurisdiction over family offense matters, permitting victims to proceed in either court or in both courts. Section 530.11 (2-a) of the CPL requires courts to notify complainants in family offense cases of the right to proceed in both criminal and family courts. These revisions allow victims of domestic violence access to the different types of relief available from the family and criminal courts. The standard of proof needed for these family court proceedings is "preponderance of the evidence"; the standard of proof for these criminal court proceedings is "evidence beyond a reasonable doubt". The family court proceeding is a civil proceeding and is for the purpose of attempting to stop violence, ending the family disruption and obtaining protection. Proceedings in family court will not result in a criminal record and are normally closed to the public. The criminal court proceeding is for the purpose of prosecuting the offender, can result in criminal conviction of the offender, and is usually open to the public. A criminal court proceeding, i.e. the filing of an accusatory instrument, must be initiated in order to request a criminal court order of protection.

Four new subdivisions, (g), (h), (i), and (j) have been added to Section 530.11(2) of the CPL and require that, when family court is not in session, criminal courts must arraign a defendant who allegedly violated a temporary order of protection, order of protection or warrant issued by the family court. This section also clarifies that a person may proceed without a court referral in either criminal or family court, or both, and authorizes criminal court to issue a family court order of protection when family court is not in session.

2. Another major provision of the Act amends Section 140.10 of the CPLby adding a new subdivision (4) and subdivision (5) which establish a mandatory arrest policy, under certain circumstances, in family offense cases. Under this section, a police officer is required to arrest a person, and must not attempt to reconcile the parties or mediate where the officer has reasonable cause to believe:

(a) a felony has been committed by such person against a member of the same family or household (with very limited exceptions set

forth in Section 155.30 (3),(4),(9) and (10) of the Penal Law); or (b) a duly served order of protection is in effect, or the respondent or defendant has actual knowledge of the order because he or she was in court when the order was issued; and the respondent or defendant committed an act or acts in violation of a "stay away" provision of such order, or committed a family offense in violation of such order; or

(c) a family offense misdemeanor has been committed by a family or household member against another family or household member, unless the victim requests otherwise. (In this situation the police officer may not ask the victim whether or not to make an arrest.)

A family offense, as defined in subdivision one of Section 530.11 of the CPL, includes acts which would constitute disorderly conduct; harassment in the first and second degree; menacing in the second and third degree; reckless endangerment; assault in the second or third degree; or an attempted assault between spouses or former spouses, or between parent and child or between members of the same family or household. Members of the same family or household means the following:

persons related by consanguinity (blood) or affinity (marriage);
persons legally married to one another;
persons formerly married to one another; and
persons who have a child in common, regardless of whether such persons have been married or have lived together at any time.

3. The new law requires the creation of a statewide registry of allorders of protection in order that state and local law enforcement personnel and members of the judiciary are able to ascertain the existence of orders of protection and temporary orders of protection, and for purposes of enforcing the mandatory arrest provisions when there has been a violation of an order of protection. The registry will be integrated with the State Police Information Network and will be accessible 24 hours a day by state and local law enforcement personnel and members of the judiciary. Standardized forms, which are compatible with the statewide registry, must be developed for orders of protection from both criminal and family courts .

4. The Act also amends Section 842 of the FCA to provide for longerorders of protection (up to three years) and amends Section 827(a) of the FCA to provide for immediate arrest of the batterer if aggravating circumstances exist. Aggravating circumstances include: physical injury or serious physical injury; the use of a dangerous weapon; repeated violations of orders of protection; prior convictions for crimes against the victim; exposure of other family or household members to physical injury which present an immediate and ongoing danger to the victim or any member of the victim's household.

In addition, the amendments to Section 842 of the FCA authorize the family court to issue a temporary order of child support without a finding of immediate or emergency need when it issues a temporary order of protection. The Act also authorizes the family court to issue a medical support

execution to secure medical insurance coverage for the alleged victim and children when the court issues a temporary order of protection.

5. The Act also amends Section 841 of the FCA to give the courtauthority to require the batterer to attend a batterers education program which may include referral to drug and alcohol counseling. The victim may not be ordered to pay the cost of counseling. The court also may order payment of restitution in an amount not to exceed $10,000.

6. The Act provides for training of police, judges, and district attorneys, in the requirements of the new law. The State Police and the State Office for the Prevention of Domestic Violence, in consultation with the Municipal Police Training Council, will be developing the training.

7. A new subdivision (15) has been added to Section 837 of the Executive Law, requiring the establishment of a standardized "domestic violence incident report form". This form must be used for reporting, recording and investigating every report of a crime or offense between members of the same family or household, whether or not an arrest is made as a result of the officer's investigation. The alleged victim must be given a copy of the report immediately, once it is prepared. The report must be retained by the law enforcement agency for not less than four years.

8. Section 812.5 of the Family Court Act is amended to expand the notice that police and district attorneys must give alleged domestic violence victims concerning the availability of services and their rights under the law. A new paragraph (h) has been added to Section 2803.1 of the Public Health Law (PHL) to require hospitals to provide the required notice to alleged victims of family offenses who are being treated by the hospital. The Commissioner of the Department of Health is required to promulgate rules for the implementation of this section.

9. A new Section 214-b has been added to the Executive Law and anew paragraph (f) has been added to Section 840.3 of the Executive Law which require the Superintendent of the State Police and the Municipal Police Training Council, respectively, to develop written policies and procedures, in consultation with the Office for the Prevention of Domestic Violence, regarding the investigation and intervention in incidents of family offenses.

10. Section 170.55(2) CPL has been amended to permit family offensecases to be restored to the calendar within a one year period of a court order to adjourn the case in contemplation of dismissal. Previously, the authority to restore these cases to the calendar expired within six months.

11. For family offense complaints filed in criminal court, twonew subdivisions, (14) & (15), have been added to Section 530.12 of the CPL which require that reasonable efforts be made to notify the complainant if the prosecuting attorney's office dismisses the criminal charges, reaches a plea agreement or declines prosecution of the case. In these cases, the People must advise the complainant of the right to file a petition in family court. Also, notice of any dispositions of cases transferred from family court to the criminal court must be given to the family court.

12. The Act amends Section 846-a of the FCA to permit the court toorder a forfeiture of bail for a violation of an order of protection. The court also may order payment of the petitioner's counsel fees in connection with a violation petition, if the court finds that the violation of its order was willful.

II. Implications for Casework Staff

1. Protective Services for Adults

Protective Services for Adults casework staff should be familiar with the provisions of this new law in order to advocate on behalf of PSA clients who may be victims of adult abuse or neglect by family or household members. When providing counseling to clients who have the capacity to make decisions on their own behalf, caseworkers should describe the provisions of the law that strengthen the effectiveness of orders of protection. These provisions include the mandatory arrest provisions for violations of orders of protection; the provision for longer orders of protection; the authority of the court to order the offender to participate in a batterers program, including alcohol and drug abuse treatment; and the authority of the court to order restitution of up to $10,000 and the payment of petitioners' counsel fees. Clients also should be advised that orders of protection and arrest warrants concerning domestic violence incidents will be placed in a statewide registry that will be accessible to law enforcment and court officials 24 hours a day, and that violations of family court orders of protection can be heard in criminal court if family court is closed.

Clients also should be advised of the possibility of proceeding in either family court, criminal court or both courts. This flexibility may allow victims of abuse to use the possible transfer of the case from family court to criminal court as leverage in obtaining compliance with family court orders of protection, such as orders to stop a perpetrator from interfering with the delivery of essential services and care.

PSA staff may need to pursue legal interventions, including applying for orders of protection on behalf of impaired victims who lack the capacity to understand the risks they are facing and the consequences of their actions. If an impaired adult is incapable of making choices on his or her own behalf, then PSA is obligated to secure services to ensure the client's safety. Districts should obtain a mental health evaluation if they have concerns about a victim's ability to make decisions on his or her own behalf. When the district is applying for an order of protection on behalf of an incapacitated client, staff should consult with police and/or the district attorney's office concerning whether to apply in family court or criminal court for the order of protection, and whether criminal charges should be filed. PSA can provide depositions to support a criminal complaint filed on behalf of an incapacitated victim. PSA staff also should be aware that all violations of existing orders of protection should be reported. Repeated violations of orders of protection may increase the degree of criminal charges that may be brought against the alleged offender.

Districts should anticipate increased referrals from law enforcement officials concerning impaired or elderly victims of abuse. PSA is listed as

a referral source on the Domestic Violence Incident Report Form. With the mandatory arrest provisions, police may be removing an alleged offender who is the sole caregiver for a dependent impaired adult. Consequently, PSA may need to arrange supportive services in the community such as homemaker or housekeeper chore services or alternative living arrangments on an emergency room and board or long-term basis.

The Department will be working with the Office for the Prevention of Domestic Violence to incorporate information on PSA in the required training on this new law for state police and other law enforcement officials. We will be sharing with them the recently released " Model Protocol Concerning the Working Relationship between Police and PSA" contained in 95 INF-10 and encouraging them to discuss this document in the training. 2. Family and Children's Services

In recent studies conducted by the Department on the foster care and preventive services caseloads, domestic violence was identified as one of the most common problems experienced by families receiving foster care and preventive services. In addition, studies of domestic violence show that, in a vast majority of households where adult domestic violence is occurring, the child(ren) in the household also are abused. Therefore, Child Protective Services staff, and Foster Care and Preventive Services staff,in both the districts and voluntary agencies should be familiar with the provisions of this new law in order to assist families who are experiencing adult domestic violence to develop effective safety strategies and appropriate intervention plans. In addition to working more effectively with clients, knowledge of the provisions of this new law will enable caseworkers to collaborate effectively with domestic violence programs, when clients are receiving these specialized services.

When a caseworker determines the existence of adult domestic violence in a family, in addition to advising the client of the availability of specialized emergency shelter and services for victims of domestic violence pursuant to Article 6-A of the Social Services Law, the caseworker should inform the client of the new mandated arrest provisions, the option to proceed with a complaint in either family or criminal court, or both courts, and the authority of the family court, when issuing a temporary order of protection, to issue a temporary order of child support including a medical support execution to ensure medical insurance coverage for the victim and the children. Clients also should be advised that the new law provides for longer orders of protection, and immediate arrest of the batterer under aggravating circumstances which include exposure of the children in the household to physical injury which presents an immediate and ongoing danger to them. Finally, the law requires a statewide registry of orders of protection and arrest warrants concerning domestic violence incidents that will be accessible to law enforcement and court officials 24 hours a day.

Having knowledge of these aggressive law enforcement and criminal justice interventions, as well as the knowledge that immediate child support and medical insurance coverage can be granted to the victim and the children, may result in the victim's willingness to involve law enforcement officials and have the batterer removed from the home. Such actions on the

part of the victim may, in some situations, alleviate the need for Child Protective Services to place the child(ren) in foster care where the domestic violence incident has placed the child(ren) in immediate risk of harm. In other situations, a child's discharge from foster care may actually be hastened when a client who is experiencing domestic violence is willing to involve the police and courts and the batterer is removed from the home. These are just a few examples of how information about The Family Protection and Domestic Violence Intervention Act of 1994 can effect a family's service plan. It is particularly important for caseworkers to make this information available to clients who do not receive specialized domestic violence services, and, therefore, may not have access to services such as counseling which addresses issues relevant to domestic violence including safety options and court advocacy.

Finally, when preparing a case involving domestic violence for a family court proceeding, the caseworker should determine whether it would be helpful in alleviating the violence to recommend that the court require the batterer to attend a batterers education program. III. Training Information

Domestic violence is an issue of power and control. Consequently, a victim of domestic violence may be fearful of disclosing information about the problem. The Department offers training courses to assist staff in understanding the general dynamics of domestic violence and to provide information on intervention strategies. The Department currently offers a one day training course entitled "Domestic Violence Training for Local District Supervisors" and a two day course "Domestic Violence Training for Child Welfare Staff". Specific information concerning these courses may be obtained by contacting Barbara Leonard, Office of Human Resource Development at (518) 474-0535.

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Donald K. Smith
Division of Services & Community Development

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Gregory Giuliano, Director
Bureau of Community Services
Office of Housing & Adult Services

OFFICE OF CHILDREN AND FAMILY SERVICES

| INFORMATIONAL LETTER | TRANSMITTAL: 99 OCFS INF-5

DIVISION: Development and Prevention Services

TO: Commissioners of Social Services

DATE: March 10, 1999

SUBJECT: Protective Services for Adults: Amendments to Penal Law Concerning Vulnerable Elderly Adults/ Chapter 381 of the Laws of 1998

SUGGESTED DISTRIBUTION: Directors of Services
Protective Services for Adults staff
Agency Attorneys

CONTACT PERSON: Any questions concerning this release should be directed to your district's Adult Services representative as follows:

Kathleen Crowe (518) 486-3451 or USERID ROF017

Carole Fox (518) 474-3167 or USERID AX5050

Michael Monahan (518) 474-9590 or USERID AY3860

ATTACHMENTS: Chapter 381 of the Laws of 1998

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv.	Manual Ref. Law & Other Legal Ref.	Misc. Ref.
97 ADM-2 95 INF-10				SSL 473.5 Penal Law 260.25, 260.30, 260.32,and	

		260.34		

The purpose of this release is to inform local districts of recent amendments to the Penal Law concerning crimes against physically disabled and vulnerable elderly persons. Local district Protective Services for Adults (PSA) staff need to be aware of these amendments since they are required, under SSL 473.5, to report to the police whenever they suspect that a criminal offense has been committed against a person being assessed for or receiving PSA. The amendments were enacted by Chapter 381 of the Laws of 1998 and took effect on November 1, 1998.

Section one of the recently enacted law expands the crime of Endangering the Welfare of an Incompetent Person (Penal Law Section 260.25) to include physically disabled persons. As amended, a person is guilty of this crime if he or she knowingly acts in a manner likely to be injurious to the physical, mental or moral welfare of a person unable to care for himself or herself due to physical disability, mental disease or defect. The crime remains a class A misdemeanor.

Sections four and five of the law establish new felony crimes of "Endangering the Welfare of a Vulnerable Elderly Person" in the second and first degree (Penal Law Sections 260.32 and 260.34). These laws significantly increase penalties where a person who is a caregiver assaults or sexually abuses a vulnerable elderly person in his or her care. Penal Law section 260.30 defines a caregiver as a person who:

* assumes responsibility for the care of a vulnerable elderly person pursuant to a court order; or * receives monetary or other valuable consideration for providing care for a vulnerable elderly person.

This definition may include guardians, licensed or certified home health care providers, private care providers, acquaintances or family members who may be receiving money or "other valuable consideration" for the care they provide.

Penal Law section 260.30 also defines a vulnerable elderly person as a person sixty years of age or older who is suffering from a disease or infirmity associated with advanced age and manifested by demonstrable physical, mental or emotional dysfunction to the extent that the person is

incapable of adequately providing for his or her own health or personal care.

A violation of Penal Law section 260.32, a class E felony, occurs, for example, when a caregiver assaults such an elderly person causing physical injury, or exposes such person to unwanted sexual contact. A violation of Penal Law section 260.34, a class D felony, occurs, for example, when an assault by a caregiver results in serious physical injury to a vulnerable elderly person.
Date March 10, 1999

These amendments to the Penal Law became effective November 1, 1998. Protective Services for Adults staff should be aware of the provisions of these new Penal Law amendments since they may be applicable to investigations of alleged abuse of physically impaired and/or vulnerable elderly adults. A copy of the law is attached. Also, you can access the law through the internet address http://www.assembly.state.ny.us. Search for Laws of 1998, Chapter 381.

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Donald K. Smith
Deputy Commissioner
Development and Prevention Services

Attachment:

New York State 1999 Chapters
Chapter 381

LAWS OF NEW YORK, 1998
CHAPTER 381

AN ACT to amend the penal law, in relation to establishing the crime of endangering the welfare of a vulnerable elderly person

Became a law July 14, 1998, with the approval of the Governor.

Passed by a majority vote, three-fifths being present.

THE PEOPLE OF THE STATE OF NEW YORK, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. The article heading of article 260 of the penal law is amended to read as follows:

OFFENSES RELATING TO CHILDREN
{AND INCOMPETENTS}, DISABLED PERSONS AND
VULNERABLE ELDERLY PERSONS S 2. Section 260.25 of the penal law is amended to read as follows:

S 260.25 Endangering the welfare of an incompetent OR PHYSICALLY DISABLED person.

A person is guilty of endangering the welfare of an incompetent OR PHYSICALLY DISABLED person when he knowingly acts in a manner likely to be injurious to the physical, mental or moral welfare of a person who is unable to care for himself OR HERSELF because of PHYSICAL DISABILITY, mental disease or defect.

Endangering the welfare of an incompetent OR PHYSICALLY DISABLED person is a class A misdemeanor. S 3. The penal law is amended by adding a new section 260.30 to read as follows:

S 260.30 VULNERABLE ELDERLY PERSONS; DEFINITIONS.

FOR THE PURPOSE OF SECTIONS 260.32 AND 260.34 OF THIS ARTICLE, THE FOLLOWING DEFINITIONS SHALL APPLY:

1. "CAREGIVER" MEANS A PERSON WHO (I) ASSUMES RESPONSIBILITY FOR THECARE OF A VULNERABLE ELDERLY PERSON PURSUANT TO A COURT ORDER; OR (II) RECEIVES MONETARY OR OTHER VALUABLE CONSIDERATION FOR PROVIDING CARE FOR A VULNERABLE ELDERLY PERSON.

2. "SEXUAL CONTACT" MEANS ANY TOUCHING OF THE SEXUAL OR OTHER INTIMATEPARTS OF A PERSON NOT MARRIED TO THE ACTOR FOR THE PURPOSE OF GRATIFYING SEXUAL DESIRE OF EITHER PARTY. IT INCLUDES THE TOUCHING OF THE ACTOR BY THE VICTIM, AS WELL AS THE TOUCHING OF THE VICTIM BY THE ACTOR, WHETHER DIRECTLY OR THROUGH CLOTHING.

3. "VULNERABLE ELDERLY PERSON" MEANS A PERSON SIXTY YEARS OF AGE OROLDER WHO IS SUFFERING FROM A DISEASE OR INFIRMITY ASSOCIATED WITH ADVANCED AGE AND MANIFESTED BY DEMONSTRABLE PHYSICAL, MENTAL OR EMOTIONAL DYSFUNCTION TO THE EXTENT THAT THE PERSON IS INCAPABLE OF ADEQUATELY PROVIDING FOR HIS OR HER OWN HEALTH OR PERSONAL CARE.

S 4. The penal law is amended by adding a new section 260.32 to read as follows:

S 260.32 ENDANGERING THE WELFARE OF A VULNERABLE ELDERLY PERSON IN THE SECOND DEGREE.

A PERSON IS GUILTY OF ENDANGERING THE WELFARE OF A VULNERABLE ELDERLY PERSON IN THE SECOND DEGREE WHEN, BEING A CAREGIVER FOR A VULNERABLE ELDERLY PERSON:

1. WITH INTENT TO CAUSE PHYSICAL INJURY TO SUCH PERSON, HE OR SHECAUSES SUCH INJURY TO SUCH PERSON; OR

2. HE OR SHE RECKLESSLY CAUSES PHYSICAL INJURY TO SUCH PERSON; OR

3. WITH CRIMINAL NEGLIGENCE, HE OR SHE CAUSES PHYSICAL INJURY TO SUCHPERSON BY MEANS OF A DEADLY WEAPON OR A DANGEROUS INSTRUMENT; OR

4. HE OR SHE SUBJECTS SUCH PERSON TO SEXUAL CONTACT WITHOUT THELATTER`S CONSENT. LACK OF CONSENT UNDER THIS SUBDIVISION RESULTS FROM

FORCIBLE COMPULSION OR INCAPACITY TO CONSENT, AS THOSE TERMS ARE DEFINED IN ARTICLE ONE HUNDRED THIRTY OF THIS CHAPTER, OR ANY OTHER CIRCUMSTANCES IN WHICH THE VULNERABLE ELDERLY PERSON DOES NOT EXPRESSLY OR IMPLIEDLY ACQUIESCE IN THE CAREGIVER`S CONDUCT. IN ANY PROSECUTION UNDER THIS SUBDIVISION IN WHICH THE VICTIM`S ALLEGED LACK OF CONSENT RESULTS SOLELY FROM INCAPACITY TO CONSENT BECAUSE OF THE VICTIM`S MENTAL DEFECT OR MENTAL INCAPACITY, THE PROVISIONS OF SECTION 130.16 OF THIS CHAPTER SHALL APPLY. IN ADDITION, IN ANY PROSECUTION UNDER THIS SUBDIVISION IN WHICH THE VICTIM`S LACK OF CONSENT IS BASED SOLELY UPON HIS OR HER INCAPACITY TO CONSENT BECAUSE HE OR SHE WAS MENTALLY DEFECTIVE, MENTALLY INCAPACITATED OR PHYSICALLY HELPLESS, IT IS AN AFFIRMATIVE DEFENSE THAT THE DEFENDANT, AT THE TIME HE OR SHE ENGAGED IN THE CONDUCT CONSTITUTING THE OFFENSE, DID NOT KNOW OF THE FACTS OR CONDITIONS RESPONSIBLE FOR SUCH INCAPACITY TO CONSENT.

ENDANGERING THE WELFARE OF A VULNERABLE ELDERLY PERSON IN THE SECOND DEGREE IS A CLASS E FELONY.

S 5. The penal law is amended by adding a new section 260.34 to read as follows:

S 260.34 ENDANGERING THE WELFARE OF A VULNERABLE ELDERLY PERSON IN THE FIRST DEGREE.

A PERSON IS GUILTY OF ENDANGERING THE WELFARE OF A VULNERABLE ELDERLY PERSON IN THE FIRST DEGREE WHEN, BEING A CAREGIVER FOR A VULNERABLE ELDERLY PERSON:

1. WITH INTENT TO CAUSE PHYSICAL INJURY TO SUCH PERSON, HE OR SHE CAUSES SERIOUS PHYSICAL INJURY TO SUCH PERSON; OR 2. HE OR SHE RECKLESSLY CAUSES SERIOUS PHYSICAL INJURY TO SUCH PERSON. ENDANGERING THE WELFARE OF A VULNERABLE ELDERLY PERSON IN THE FIRST DEGREE IS A CLASS D FELONY. S 6. This act shall take effect November 1, 1998.

The Legislature of the STATE OF NEW YORK SS:

Pursuant to the authority vested in us by section 70-b of the Public Officers Law, we hereby jointly certify that this slip copy of this session law was printed under our direction and, in accordance with such section, is entitled to be read into evidence.

JOSEPH L. BRUNO SHELDON SILVER

TEMPORARY PRESIDENT OF THE SENATE SPEAKER OF THE ASSEMBLY

NEW YORK STATE
OFFICE OF CHILDREN & FAMILY SERVICES

Andrew M. Cuomo *Governor* 52RENSSELAER, NY 12144 WASHINGTON STREET **Gladys Carrión, Esq.** *Commissioner*

Informational Letter

Transmittal:	12-OCFS-INF-01
To:	Commissioners of Social Services
Issuing Division/Office:	Division of Child Welfare and Community Services
Date:	January 17, 2012
Subject:	**Sharing of Confidential Client-identifiable Information Between Child Protective Services (CPS) and Protective Services for Adults (PSA)**
Suggested Distribution:	Directors of Social Services CPS Supervisors and Staff PSA Supervisors and Staff Agency Attorneys

Contact Person(s):	Please direct questions about this policy to: Buffalo Regional Office — Dana Whitcomb (716) 847-3145 Dana.Whitcomb@ocfs.state.ny.us Rochester Regional Office — Karen Buck (585) 238-8201 Karen.Buck@ocfs.state.ny.us Syracuse Regional Office — Daniel E. Comins (315) 423-1200 Daniel.Comins@ocfs.state.ny.us Albany Regional Office — Kerri Barber (518) 486-7078 Kerri.Barber@ocfs.state.ny.us Spring Valley Regional Office — Raymond Toomer (845) 708-2498 Raymond.Toomer@ocfs.state.ny.us NYC Regional Office — Pat Beresford (212) 383-1788 Patricia.Beresford@ocfs.state.ny.us Native American Services — Kim Thomas (716) 847-3123 Kim.Thomas@ocfs.state.ny.us For questions relating to PSA: Director of Adult Services — Alan Lawitz (518) 474-9431 Alan.Lawitz@ocfs.state.ny.us
Attachments:	Attachment A: Chapter 440 of the Laws of 2011 Attachment B: Model letter, Authorization for Information
Attachments Available Online:	Attachment A available at: http://public.leginfo.state.ny.us/menugetf.cgi Attachment B is posted, in Word format, with this policy at: http://www.ocfs.state.ny.us/main/policies/external

Filing References

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
		18 NYCRR 457, 18 NYCRR 457.16	SSL § 422(4)(A) SSL § 473(1) SSL § 473-e(2)		

I. Purpose

The purpose of this release is to provide guidance to local departments of social services (LDSS) as to permissible means for the sharing of client-identifiable information between Child Protective Services (CPS) and Protective Services for Adults (PSA) units of an LDSS. The release includes information about a new provision of law, enacted as Chapter 440 of the Laws of 2011, as well as information about other applicable longstanding provisions of law. Some LDSSs have sought clarification of permissible means under current law of sharing client identifiable CPS information with PSA, and the enactment of this new chapter law makes it necessary to provide such guidance at this time.

II. Background

CPS: CPS is a state-mandated service provided without regard to income by the CPS unit in an LDSS. CPS investigates reports of suspected child abuse and maltreatment in order to protect children from further abuse or maltreatment. After an investigation, all CPS reports are either "indicated," if there is some credible evidence that one or more persons abused or maltreated one or more children, or "unfounded," where no such evidence is found. Reports of child abuse or maltreatment as well as any other information obtained, reports written or photographs taken concerning such reports of child abuse or maltreatment that are in the possession of an LDSS or OCFS are confidential in accordance with Social Services Law (SSL) Section 422. Such information may only be disclosed where authorized by statute. Unauthorized disclosure of confidential CPS information may subject the individual responsible for such disclosure to criminal and/or civil penalties. CPS information contained in reports pending determination or in indicated reports of child abuse or maltreatment may be disclosed only where and to the extent authorized by SSL Section 422(4)(A)(a)-(aa). Among the exceptions in which disclosures are permitted are disclosures made pursuant to court order or upon the authorization of the subject of the report or other person named in the report.

Another exception to the prohibition on disclosing CPS information in reports pending determination or in indicated reports of child abuse or maltreatment, which may be of particular interest to PSA units, is set forth in SSL Section 422(4)(A)(o). That section permits a CPS or an LDSS to provide CPS information to a provider or coordinator of services to which the CPS or LDSS has referred a child named in a CPS report or the child's family, or to whom the child or the child's family have referred themselves at the request of CPS or the LDSS, where the child has been reported to the Statewide Central Register of Child Abuse and Maltreatment. The statute authorizes CPS to provide reports or other information necessary to enable the provider or coordinator of services to establish and implement a services plan for the child or family, to monitor the provision or coordination of services, or to directly provide services to the child or family. Such disclosure may not include information that would identify the source of the report, absent the written consent of the source. CPS information received by the provider or coordinator of services is also subject to limitations on redisclosure, as set forth in SSL Section 422(4)(A).

There is no authority in SSL Section 422(4)(A)(o) for the disclosure to providers or coordinators of services of CPS information from an <u>unfounded</u> report of child abuse or maltreatment.

A PSA unit of an LDSS is considered to be a permissible provider or coordinator of services to which CPS may refer a family involved in a CPS case that is pending determination or that is an indicated report.

A new exception permitting disclosure of certain CPS reports to PSA was enacted pursuant to Chapter 440 of the Laws of 2011. Known for the purposes of this release as the "access while a child" exception, this new provision, signed into law on August 17, 2011, and effective immediately upon enactment, added SSL§422(4)(aa) to provide specific authority for PSA to receive confidential CPS records on pending or indicated reports of child abuse or maltreatment when a social services official who is investigating whether an adult is in need of PSA has reasonable cause to believe such adult may be in need of protective services for adults due to the conduct of an individual or individuals who had access to such adult when such adult was a child, and the child abuse or maltreatment reports and information are needed to further the present PSA investigation. A copy of this new law is attached as Appendix A.

PSA: PSA is a state-mandated service which, pursuant to SSL Section 473(1), is provided without regard to income by a PSA unit in an LDSS to assist adults age 18 or older who:

(a) because of mental or physical impairments,
(b) are unable to manage their own resources, carry out the activities of daily living, or protect themselves from physical abuse, sexual abuse, emotional abuse, active, passive or self-neglect, financial exploitation or other hazardous situations without assistance from others, and
(c) have no one available who is willing and able to assist them responsibly.

PSA staff receive and investigate referrals, interview clients and collaterals to determine eligibility for services, assess client risks, develop services plans to address identified risks and, as appropriate, provide or arrange for the provision of protective services in accordance with the services plan. PSA reports, as well as the names of referral sources, photographs and any other information obtained concerning such reports, that are in the possession of the LDSS or OCFS are confidential, pursuant to SSL Section 473-e(2), and may only be disclosed where authorized by that statute. PSA may disclose confidential information to a provider of services of a current or former PSA client when the LDSS believes that such information is necessary to determine the need for or to provide or to arrange for the provision of such services [SSL Section 473-e(2)(b)].

III. Program Implications

PERMISSIBLE MEANS OF SHARING CLIENT IDENTIFIABLE CPS
INFORMATION BY CPS TO PSA

A. Referral by CPS to PSA

In accordance with SSL Section 422(4)(A)(o), an LDSS or CPS may disclose clientidentifiable CPS information contained in a report pending determination or an indicated report to "a provider or coordinator of services" to which a CPS or an LDSS

has referred the child or the child's family, or to which the child or child's family has referred themselves at the request of the CPS or LDSS. This authorizes the sharing of CPS information either within the same LDSS or with a PSA unit in a different LDSS to which a referral has been made. PSA is considered to be "a provider or coordinator of services" under this provision.

These provisions apply to an open or indicated CPS report when there is either: (i) a referral made by CPS or the LDSS to PSA of an adult in the child's family who may be in need of PSA, or (ii) a referral by the child's family to PSA, made at the request of CPS or an LDSS, where the CPS information is necessary to enable the LDSS PSA to establish and implement a plan of service to a vulnerable adult, or to monitor the provision or coordination of PSA services, or to directly provide PSA services to the child's family. The term "family" for this purpose includes the children, the parents, and other adults residing in the same household as the children. An example of a situation in which CPS may refer a family to PSA and share CPS information on pending or indicated CPS reports is one where the CPS investigation identifies that there is an adult in the child's household who may be in need of PSA, as set forth in SSL Section 473. Such referral may be made during or at the conclusion of a CPS investigation. Referral is also appropriate if an individual who is part of a closed CPS case communicates with CPS about an issue relating to the abuse, neglect or financial exploitation of a vulnerable adult.

NOTE:

- CPS information provided to PSA may **not** include the identity of the source of the report, absent the written consent of the source.
- CPS information may be provided by CPS to the PSA unit as a provider or coordinator of services pursuant to SSL Section 422(4)(A)(o) only where there is a CPS report pending determination or an indicated CPS case, but may not be shared where a CPS case is "unfounded."

B. Release/Consent to Disclose

In accordance with SSL Section 422(4)(A), the subject of a report (i.e., the person who is named in a report as being responsible for the abuse or maltreatment of the child) or another person named in the report (the child named in the report or the child's parent, guardian, custodian or other person legally responsible for the child who has not been named in the report as being responsible for the abuse or maltreatment) may consent to the disclosure of client-identifiable CPS information in open (pending determination) or indicated reports.

Such consent may be documented through the execution of a written release that expressly refers to the disclosure of CPS information.

In accordance with SSL Section 422(5)(a)(iv), the subject of the report may also authorize the disclosure of an unfounded CPS report to LDSS PSA through a release.

Other persons named in the report may not authorize the disclosure of an unfounded CPS report.

Please refer to Appendix B for a model of a consent form authorizing disclosure of CPS information.

C. Multidisciplinary Investigative Team

In accordance with SSL Section 422(4)(A)(x), LDSS CPS may disclose client-identifiable CPS information on pending or indicated CPS reports to members of a local Multidisciplinary Investigative Team **(**MDT**)** established by the LDSS. In accordance with SSL Section 423(6), LDSS PSA staff may be members of an MDT. Participation in an MDT would enable LDSS PSA to become aware of CPS reports**,** including specifically reports of physical abuse, sexual abuse, child fatalities, and serious and/or ongoing maltreatment. PSA would be able to participate jointly with CPS and other appropriate MDT member agencies in the investigation of cases involving vulnerable adults who may be eligible for PSA.

In accordance with SSL Section 422(5)(a)(iii), members of an MDT have access to legally sealed unfounded CPS reports when there is a subsequent report involving the same subject, child, or sibling of a child named in an unfounded report. In such situations, LDSS PSA staff who are members of an MDT might sometimes obtain access to unfounded report information in the context of the investigation of a subsequent CPS report. In accordance with SSL Section 423(6), LDSS PSA staff who are members of an MDT may share client-identifiable PSA information concerning a child or a child's family with other members of the MDT to facilitate the investigation of suspected child abuse or maltreatment.

D. PSA Requests for Access to CPS Information

The situation may arise in which a PSA unit has reason to believe that there may have been prior or ongoing CPS involvement with a family that is also being served by the PSA unit and that the CPS information may be of assistance to the PSA unit in meeting its statutory and regulatory duties and obligations.

In order for the PSA unit to access CPS information, one of the exceptions to the ban on sharing information included in SSL Sections 422(4)(A)(a)-(aa) would have to apply. The applicable exceptions are those pertaining to a court order, MDT, CPS release, provider or coordinator of services, or the new "access while a child" exception noted on page 3.

A PSA unit would have a right to access CPS information on pending and indicated CPS cases if the PSA unit is granted a court order allowing such access. This exception is most likely to occur when the PSA unit is seeking CPS information in the possession of another LDSS. In addition, the PSA unit would have a right to access CPS information from pending and indicated reports if the subject of the CPS report

or any other person named in such report (including the PSA client) executes a release that specifically includes CPS information, subject to the same limitations noted in section B of this Informational Letter. Where access to CPS information is authorized by either a court order or a CPS-specific release, the PSA unit is not required to provide further justification to the CPS unit to gain access to CPS information.

If the PSA unit is not able to access CPS information by either a court order, a CPSspecific release, or through an MDT, the PSA unit may request that the CPS unit share CPS information using the provider or coordinator of services exception in SSL Section 422(4)(A)(o). For this exception to apply, the family must otherwise satisfy the requirements in Section 422(4)(A)(o), which are that:

- the family was referred to the PSA unit by CPS or an LDSS, or
- the family referred themselves at the request of CPS or an LDSS and, for either type of referral,
- the PSA unit needs the CPS information to establish and implement a plan of PSA for the family, or to monitor the provision of PSA, or to directly provide PSA, including a PSA investigation.

Should the PSA unit make such a representation to the CPS unit within an LDSS, the CPS unit may share with the PSA information on pending and indicated CPS reports regarding such family, subject to the limitations referenced in section A of this Informational Letter. The PSA unit's request for CPS information should be made in writing to the CPS unit and should set forth the basis for the request. Where CPS information is provided to the PSA unit, the LDSS should document the basis for the transfer of such information.

Finally, the PSA unit may also request confidential CPS records under the "access while a child exception," where the PSA unit is investigating whether an adult is in need of PSA and has reasonable cause to believe such adult may be in need of protective services due to the conduct of an individual or individuals who had access to such adult when such adult was a child, and such records and information are needed to further the present investigation.

RECOMMENDED ACTION:

LDSS staff (Directors of Services, CPS and PSA, together with LDSS attorneys) should review and consider the above mentioned permissible means available under current law to enable CPS, a local or regional MDT, and PSA to share confidential information under certain circumstances; determine how these provisions may apply to future cases; and determine what changes in procedures may be necessary or desirable as a result. In particular, consideration should be given to whether an LDSS may wish to establish an MDT - or expand an existing MDT - to include PSA as well as CPS staff, in order to better address particular PSA cases.

LDSS CPS staff and MDT member agencies should become familiar with the eligibility criteria for PSA, with possible indicators of abuse, neglect and exploitation of vulnerable adults who may be eligible for PSA, and with the range of services available under PSA. Such information is available under the "Protective Services for Adults" sections of the OCFS Internet and intranet websites; in Publication 1307, "Protecting Adults: A Community Concern"; in Publication 1326, "Protecting Adults From Abuse and Neglect"; and in Publication 4664, "Financial Exploitation of Elderly and Impaired Adults." More detailed information concerning PSA services, procedures and policies can be found in numerous Administrative Directives, Information Letters and Local Commissioner Memoranda issued in previous years, and may be obtained by contacting the OCFS Bureau of Adult Services.

/s/ Laura M. Velez

Issued By:
Name: Laura M. Velez
Title: Deputy Commissioner
Division/Office: Division of Child Welfare and Community Services

92-INF-054 APS Access to Hospital Records for the Purpose of Conducting APS Investigation on Behalf of Persons Referred by Hospitals

INFORMATIONAL LETTER	TRANSMITTAL: 92 INF-54
	DIVISION: Services and Community Development
TO: Commissioners of Social Services	
	DATE: December 14, 1992

SUBJECT: Protective Services for Adults (PSA): Access to Hospital Records for the Purpose of Conducting PSA Investigations on Behalf of Persons Referred by General Hospitals

SUGGESTED DISTRIBUTION:
Directors of Services
Adult Services Staff
Agency Attorneys
Staff Development Coordinators

CONTACT PERSON: Any questions concerning this release should be directed to your district's Adult Services Representative at 1-800-342-3715 as follows:

Thomas Burton	ext. 432-2987
Kathleen Crowe	ext. 432-2996
Michael Monahan	ext. 432-2667
Janet Morrissey	ext. 432-2864, or
Irvin Abelman	at 1-800-554-5391

ATTACHMENTS: None

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
92 INF-26		303 357 403 457	Section 136 & Article 9B SSL Article 27-F of the Public Health Law		Part 405 of Department of Health Regulations (10 NYCRR)

The purpose of this release is to inform local social services districts of a recent legal opinion from the New York State Department of Health (DOH) regarding the authority of a general hospital to provide access to a patient's medical records for the purpose of evaluating the need for Protective Services for Adults (PSA) when that patient was referred to PSA by the hospital.

Some local social services districts have encountered difficulty in obtaining hospital records for the purpose of conducting PSA investigations in situations in which the hospitals themselves made the referrals to PSA. In response to this problem, the Department contacted DOH and requested a legal opinion authorizing information sharing by hospitals in order for districts to assess the need of these patients for PSA. We have recently been advised by DOH that access to medical records can be provided to PSA staff, based on the following provisions of Public Health Law, Social Services Law, DOH regulations, and Department regulations.

Section 405.10(a)(5) of the DOH regulations (10 NYCRR) requires hospitals to ensure the confidentiality of patient records and permits the release of original medical records and information from or copies of records only to hospital staff involved in treating the patient or to individuals as permitted by Federal and State laws. Article 9-B of the Social Services Law (SSL) authorizes social services officials to receive and investigate reports of individuals who may be in need of protection; arrange for medical and psychiatric services to evaluate, safeguard and improve the circumstances of persons with serious impairments; and obtain court ordered access to those persons believed to be in need of PSA if they are refused access. Section 473(2)(a) SSL recognizes that the effective delivery of PSA requires a network of professional consultants and service providers and requires local social services districts to plan with other public, private and voluntary agencies, including health agencies, for the purpose of assuring maximum local understanding, coordination and cooperative action in the provision of appropriate services. Part 357 of the Department's regulations sets forth the requirements for safeguarding confidential information; additional guidance with regard to PSA clients was provided in 92 INF-26.

Given the purpose of the PSA statute and the confidentiality protections accorded medical records by PSA, DOH accepts Article 9-B SSL as sufficient statutory authority to allow PSA staff access under Section 405.10 of DOH regulations to those parts of the medical records of a hospital patient referred to PSA by the hospital that are not otherwise made confidential by statute. Additionally, Sections 303.7 and 403.9 of the Department's regulations satisfy the mandate of Article 27-F of the Public Health Law (PHL) with regard to confidential HIV related information, thereby

The Department expects that this interpretation, which has been provided by the Department of Health, will make it easier for local social services districts to gain access to medical records in order to conduct PSA assessments of patients referred to PSA by hospitals. However, in order to assure the confidentiality of medical information which has been requested from a hospital, we recommend that PSA staff review the provisions of 92 INF-26 as well as the information in this transmittal.

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Peter R. Brest
Associate Commissioner
Office of Housing and Adult Services

INFORMATIONAL LETTER

TRANSMITTAL: 92 INF-55

DIVISION: Services and Community Development

TO: Commissioners of Social Services

DATE: December 16, 1992

SUBJECT: Protective Services for Adults (PSA): Model Hospital Agreement

SUGGESTED DISTRIBUTION: Directors of Services
Adult Services Staff
Staff Development Coordinators

CONTACT PERSON: Any questions concerning this release should be directed to your district's Adult Services Program Representative at 1-800-342-3715, as follows:
Thomas Burton, ext. 432-2987
Kathleen Crowe, ext. 432-2996
Michael Monahan, ext. 432-2667
Janet Morrissey, ext. 432-2997, or
Irvin Abelman at 1-800-554-5391

ATTACHMENTS: Model Hospital Agreement (Available on-line)

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
90 ADM-40 92 INF-4		457	Article 9-B		

The purpose of this release is to inform local social services districts of a model Protective Services for Adults (PSA)/Hospital Discharge Planning Agreement which was developed by the Department, in collaboration with the Hospital Association of New York State (HANYS).

The Department issued 90 ADM-40, which was effective on January 1, 1991, to clarify the eligibility criteria for PSA and to define the role of PSA for persons being served by other providers, including hospitals. This directive addresses the joint responsibilities of PSA and hospital discharge planning staff for individuals who may be in need of PSA upon their release from a hospital. This directive also requires local social services districts to initiate efforts to establish written agreements on discharge planning with local hospitals by June 30, 1991.

In the Spring of 1991, the Department conducted six regional technical assistance sessions to assist local social services district staff with the implementation of 90 ADM-40. In the technical assistance sessions and in subsequent discussions with local staff, we were informed that many hospitals were reluctant to enter into agreements on discharge planning with local social services districts. During this same period of time, representatives of HANYS advised us about the concerns of hospitals regarding some of the proposed agreements that were being presented to them by local social services district staff.

In response to the concerns of both local social services district and hospital discharge planning staff, the Office of Housing and Adult Services and HANYS have developed a model agreement, a copy of which is attached. This agreement reflects the input of both local PSA and hospital discharge planning staff and should be used as the basis for negotiating discharge planning agreements at the local level. Copies of the model agreement also have been sent to hospitals throughout the state, which have been encouraged by HANYS to work cooperatively with local social services districts in the development of written discharge planning agreements.

_____

Peter R. Brest
Associate Commissioner
Office of Housing and Adult Services

MODEL PSA/HOSPITAL AGREEMENT

PURPOSE:

This agreement is between _____ Hospital (Hospital) and the _____ County Department of Social Services Protective Services for Adults Program (PSA). The agreement sets forth the joint responsibilities of PSA and the Hospital for patients who are identified as being in need of PSA upon discharge to the community. The agreement also sets forth the responsibilities of PSA and the Hospital for active PSA clients who are admitted to the Hospital. The terms of this agreement are consistent with State Social Services Law and regulations governing PSA and State Health Department Law and regulations governing discharge planning.

PSA ELIGIBILITY:

PSA is available to all individuals 18 years of age or older who meet all of the following three (3) criteria:

1) are incapable of meeting their own basic needs or protecting themselves from harm due to mental and/or physical incapacity; and

2) are in need of protection from actual or threatened harm, neglect or hazardous conditions caused by the action or inaction of either themselves or other individuals; and

3) have no one else available who is willing and able to assist them responsibly.

Hospital inpatients and emergency room patients who are awaiting discharge to the community and who, upon discharge, can be expected to meet the above criteria for PSA eligibility, are eligible for PSA.

Active PSA clients who are admitted to the Hospital continue to be eligible for PSA throughout their hospitalization, with the following exceptions:

1) Another responsible or appropriate person or agency assumes responsibility for the patient; or

2) The patient's medical, social and financial situation is stabilized and a clinical determination has been made that the patient will be discharged to a residential care facility If DSS is acting as the patient's conservator or committee, the case must remain active with PSA until DSS is relieved of its fiduciary responsibility by the appointing court. If PSA is acting as the patient's representative payee, the PSA case must remain open until PSA notifies the appointing agency that PSA will relinquish this responsibility; or 3) the patient regains the capacity for self care and protection.

Hospital inpatients and emergency room patients who will be discharged directly to supervised residential care settings, and who were not active PSA cases upon admission to the Hospital, are not eligible for PSA. These patients are considered to have other systems available to meet

their basic needs for care and protection, namely the Hospital and the residential care facility.

PSA REFERRAL PROCESS:

A Hospital Discharge Planner may refer inpatients or emergency room patients who appear to meet the criteria for PSA eligibility by calling the PSA intake unit at _____ between 9AM and 5PM, Monday through Friday, and such other hours that have been agreed upon by both parties.

RESPONSIBILITIES OF PSA:

Upon receipt of a PSA referral from the Hospital, the PSA Intake Worker will immediately determine whether to accept the case for a PSA assessment, unless additional information is needed. If additional information is needed which is pertinent to the patient's potential eligibility for PSA, the PSA intake worker may need to request additional information from the Hospital or may need to contact other collateral sources before a decision is made whether to accept the case for a PSA assessment. In any case, a decision will be made whether to accept the case for assessment within 24 hours after the referral is received. If, on the basis of information supplied by the Hospital and any additional information obtained by the intake worker, it appears that the patient may be eligible for PSA, the case will be accepted for assessment.

A case will be rejected for assessment only if PSA eligibility can be conclusively ruled out. If any doubt remains about a patient's PSA eligibility, the case will be accepted for assessment.

Upon acceptance of a referral for PSA assessment, the assigned PSA caseworker will arrange to visit the client in the hospital as soon as possible, but within three business days, unless it is not possible to visit the client in the hospital. Any referral involving a patient who is at risk of leaving or being taken from the hospital against medical advice to return to a dangerous situation in the community will be considered life threatening, and PSA will make an effort to make an immediate visit to the client, but, in any case a visit will be made within 24 hours.

PSA staff will work with Hospital Discharge Planning staff to evaluate the client's situation and service needs in the community, the suitability of the individual's home environment, and the availability of family members and significant others to provide required care upon discharge.

PSA staff will notify Hospital Discharge Planning staff of the results of the PSA assessment. PSA staff will work collaboratively with Hospital Discharge Planning staff throughout the assessment process to insure a prompt, appropriate and safe discharge plan for the client. If necessary, PSA may request a reasonable postponement of discharge until necessary services are in place or until the client's safety can be assured in the community. PSA will support its determination that a client cannot be safely discharged to the community by specifying social and/or environmental conditions, or other circumstances, in the home which would be likely to cause serious harm to the client upon discharge.

If PSA requests postponement of a discharge, the Hospital may request payment for up to 30 days of emergency room and board in accordance with Section 457.1(c)(5) of State Department of Social Services regulations if each of the following conditions are met:

1) the patient is cleared for discharge, all of the patient's medical needs have been met and all other reimbursement sources for hospital care have been exhausted;

2) the patient would be at risk of serious harm in the community if the discharge takes place; and

3) additional time is needed by PSA to take steps to assure a habitable home environment for the patient which is free of any social or environmental conditions which would be likely to result in serious harm to the patient.

The Social Services District and the Hospital will negotiate a per diem rate for emergency room and board payments.

As soon as reasonably possible, but no later than 30 calendar days after the referral date, a determination will be made whether the case will be opened for PSA. In completing its assessment and making its eligibility determination, PSA will be as sensitive as possible to the projected discharge date. The Hospital Discharge Planner will be kept promptly and fully informed of the client's status and the results of the PSA eligibility decision.

If the case is accepted for services, PSA will keep the Hospital Discharge Planner informed of the PSA services plan as long as the client remains hospitalized. PSA will assist Hospital discharge planning staff to obtain all available services that are necessary to assure a safe environment for the client in the community. PSA will assume primary case management responsibility for the case at the time of the patient's discharge to the community.

If an adult receiving PSA in the community is hospitalized, PSA will remain involved in the case throughout the adult's hospitalization, or until the client's medical, social and financial situation is stabilized and the adult becomes ineligible for PSA, as set forth above.

PSA staff will be available for consultation and training to Hospital staff on PSA issues.

RESPONSIBILITIES OF THE HOSPITAL:

The Hospital will contact PSA as soon as possible after a patient's admission to the Hospital once the patient has been identified as being potentially in need of PSA upon discharge.

If the Hospital believes that a patient may have been receiving PSA at the time of hospitalization, the Hospital will notify PSA of the patient's admission as soon as possible after the admission. If the case is determined to be an active PSA case, the Hospital will immediately involve PSA in the discharge planning process.

The Hospital will include in its referrals to PSA all available information regarding the patients' medical, psychiatric and social condition which may be necessary in determining PSA eligibility and an appropriate PSA Services Plan.

Whenever circumstances require, the Hospital will invite PSA to participate in an interagency discharge planning conference.

The Hospital will arrange for all necessary post hospital services. The Hospital retains primary responsibility for case management until the patient is discharged from the hospital.

The Hospital ensures that consistent with Section 405.22 of State Health Department regulations pertaining to discharge planning, the following conditions will be present before a patient is discharged:

o The patient must be determined by a physician to be medically ready for discharge.

o A discharge plan must be in place which meets the patient's post-hospital needs.

o All necessary post-hospital services must be in place or have been made reasonably available to the patient.

o The patient must be returning to an environment which is free of social, environmental or other conditions which are likely to result in serious harm to the patient.

The Hospital will establish procedures to train Hospital staff to assure the identification of appropriate PSA referrals as early as possible in the discharge planning process. The Hospital will notify PSA of any training opportunities offered by the Hospital which might benefit PSA staff.

CAPACITY OF PATIENTS TO CONSENT:

Both PSA and the Hospital recognize that unless a patient lacks decision making capacity, the patient has a right to choose a discharge plan that either the Hospital or PSA, or both, deem to be unwise, or to leave the Hospital Against Medical Advice (AMA).

The Hospital agrees to try to secure a psychiatric evaluation prior to discharge for any patient who is choosing a potentially dangerous course of action if there is any reasonable doubt about the patient's capacity to make and understand care related decisions. The Hospital agrees to share the the results of the psychiatric evaluation with PSA, insofar as it may be pertinent to the patient's PSA eligibility or PSA services plan.

If a psychiatric evaluation concludes that a patient does not have the capacity to make care related decisions and the patient will be at risk of harm upon discharge, the Hospital will take necessary action to postpone the discharge in order to obtain necessary services to ensure that the patient will be returning to a safe environment. If it is determined that court authorization is required to obtain placement of a patient in a residential care facility, the Hospital will assume responsibility for

initiating the appropriate legal intervention if the patient was not an active PSA case upon admission to the hospital.

PSA will initiate appropriate legal interventions on behalf of patients who were active with PSA upon admission to the Hospital and patients who are eligible for PSA and have a community discharge plan in accordance with requirements set forth in Section 405.22 of State Department of Health discharge planning regulations.

If an inpatient or emergency room patient of the Hospital, including a PSA client, is incapable of giving informed consent for medical treatment, the Hospital is responsible for proceeding in accordance with appropriate provisions of law to provide the necessary treatment.

When involuntary legal intervention is initiated by the Hospital on behalf of a PSA client or applicant, PSA will provide assistance and consultation on legal issues to the Hospital as long as such intervention is determined by PSA to be in the best interest of the patient. Such assistance may include providing supporting documentation, legal affidavits and testimony by PSA staff to support a legal intervention initiated by the hospital on behalf of a PSA client or applicant. PSA will also provide consultation to the Hospital on legal issues involving patients who are not PSA clients.

CONFLICT RESOLUTION:

In cases of disagreement between Hospital and PSA staff about a patient's eligibility for PSA or the appropriateness of a discharge plan, every effort shall be made to resolve the conflict at the practitioner level. If resolution cannot be achieved at that level, supervisory staff in each agency will confer to reach an acceptable resolution.

If a dispute cannot be achieved at the supervisory level, the dispute will be referred to the Director of PSA (Director of Social Services) and Director of Social Work of the Hospital, for resolution.

Both parties agree to make every effort to resolve disputes through the internal conflict resolution process discussed above. If a dispute cannot be resolved by the two parties, each party reserves the right to pursue an equitable resolution of the matter through one the complaint resolution mechanisms discussed in the paragraph below.

If PSA believes that a proposed discharge plan for a PSA client is inappropriate, and resolution of the matter cannot be achieved in bilateral discussions with the Hospital, PSA may initiate a request for a Discharge Review with the appropriate Discharge Review Agent. If a discharge occurs which PSA believes to have been inappropriate, PSA may initiate a formal complaint to the appropriate Regional Office of the New York State Health Department. The Hospital may contact the New York State Department of Social Services about any dispute pertaining to PSA eligibility which cannot be resolved locally.

If either PSA or the Hospital submits a dispute to an outside agency for resolution, the party bringing the matter to an outside agency will notify the other party in writing of the details of the complaint. Notification to

the other party shall be made as promptly as possible, preferably prior to the submission of the complaint. COMMUNITY REFERRALS:

Hospital outpatients and patients in the community served by other Hospital programs who meet the criteria for PSA eligibility set forth above are eligible for PSA. Community referrals by Hospital staff may be made to the PSA intake unit during the hours set forth above.

Upon acceptance of a community referral for PSA assessment, the assigned PSA caseworker will arrange to make a home visit to the client within three working days, unless a life threatening situation exists. If a life threatening situation appears to exist, PSA will commence an immediate investigation and a home visit will be made within 24 hours if the patient remains in the community. A determination will will be whether the case will be opened for PSA no later than 30 calendar days after the referral date. PSA will promptly notify Hospital staff of its determination of the patient's eligibility or ineligibility for PSA.

TERMS OF AGREEMENT:

PSA and the Hospital will review of the terms of this agreement at least annually.

Changes in the agreement may be made at any time by mutual consent of PSA and the Hospital.

Either party may terminate this agreement by giving 30 days written notice to the other party.

ADMINISTRATIVE DIRECTIVE **TRANSMITTAL:** 90 ADM-025
DIVISION: Medical

TO: Assistance
Commissioners of Social Services

DATE: August 24, 1990

SUBJECT:
Family Type Home For Adults: Long Term Home Health Care Program Services Provided in Adult Care Facilities

SUGGESTED DISTRIBUTION:	Directors of Services Medical Services Staff Adult Services Staff Family-Type Home Coordinators Staff Development Coordinators
CONTACT PERSON:	Any questions concerning this release should be directed to Al Roberts, Division of Medical Assistance, and Frank Rose, Division of Adult Services, by telephoning 1-800-342-3715, extension 35539 and 432-2404 respectively. The contact person for Family Type Homes is Cheryl Flanigan, Division of Adult Services, at 432-2997.
ATTACHMENTS:	See Attachment 1 for listing of Attachments

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
83 ADM -74 85 ADM -27		360-6.6 505.21 and	Chapter 854 of the Laws of 1987		SSL 367-c.5
88 INF -20		485.17	Chapter 895 of the Laws of 1977		

I. PURPOSE

The purpose of this directive is to notify social services districts of the implementation of a revised Section 505.21 and a new Section 485.17 to the Department's regulations which incorporate the provisions of Chapter 854 of the Laws of 1987 expanding the availability of Long Term Home Health Care Program (LTHHCP) services to residents of all adult care facilities (ACFs) except shelters for adults.

II. BACKGROUND

Much has been written about the rate at which New York State's population is aging, and the dramatic growth of the age groups most apt to seek long term care. It is clear that the need for long term care services will continue unabated.

A general reduction in the rate at which residential health care facility beds are established, and the creation of incentives for intensifying the levels of care in skilled nursing and health related facilities, has shifted public interest to the home and community based long term care options.

For persons who have a suitable home and informal caregivers capable of supporting them, the shift is ideal. For someone without a home, the alternatives have become increasingly limited. Adult care facilities must be considered one of the primary alternatives. However, this requires that the adult care facility be considered not in relation to the skilled nursing/health related facility continuum, but in relation to the communitybased home health care system. Historically, Social Services Regulations (360-6.6, formerly 360.21) have defined the adult care facility as being an individual's home, and have permitted Medical Assistance reimbursement for the provision of personal care and certified or licensed home health care agency services to its residents.

Chapter 854 of the Laws of 1987 deletes the statutory prohibitions against providing Long Term Home Health Care Program services in adult care facilities other than shelters for adults and offers yet another long term care option: the adult care facility and the Long Term Home Health Care Program. This statutory change is consistent with the generally held belief that social models of congregate care, i.e., adult care facilities, in combination with medical service components can provide appropriate long term care options.

Chapter 854 was effective on April 1, 1988. It was the subject of two previously released Departmental communications: 88 INF-20 and Adult Care Facility INF-22, both dated March 24, 1988.

III. PROGRAM IMPLICATIONS

Significant elements of existing policy and that necessitated by Chapter 854 of the Laws of 1987 are listed below.

(A) Where Services Can Be Provided

The statutory prohibition, Public Health Law, Section 3602(8), against providing LTHHCP service in private proprietary homes for adults, private proprietary convalescent homes, residences for adults and public homes is deleted, allowing service to be provided in the following types of adult care facilities defined in Department regulation 485.2:

(1) Adult Homes

An adult home is established and operated for the purpose of providing long term residential care, room, board, housekeeping, personal care and supervision to five or more adults unrelated to the operator.

(2) Enriched Housing Program

An enriched housing program is established and operated for the purpose of providing long term residential care to five or more adults, primarily persons age sixty-five years or older, in community-integrated settings resembling independent housing units. The program provides or arranges the provision of room, and provides board, housekeeping, personal care and supervision.

(3) Residence for Adults

A residence for adults is established and operated for the purposes of providing long term residential care, room, board, housekeeping and supervision to five or more adults unrelated to the operator.

(4) Family-type Home

A family-type home for adults is established and operated for the purpose of providing long term residential care, room, board, housekeeping, personal care and/or supervision to four or fewer adult persons unrelated to the operator.

(B) Where Services Can Not Be Provided

Chapter 854 retains a specific prohibition against providing LTHHCP services in shelters for adults.

(C) What Is A Long Term Home Health Care Program (LTHHCP)?

Long Term Home Health Care Programs are granted operating certificates by the New York State Department of Health under authority contained in Public Health Law, Section 3610 and Part 770 of New York State Department of Health Regulations.

A LTHHCP may be associated with a certified home health agency, a residential health care facility or hospital and is required to provide nursing, medical social services and home health aide services (e.g., physical therapy, speech therapy, respiratory therapy, nutritional counseling, and personal care services including homemaker and housekeeper). In addition, a LTHHCP may provide seven waived services (home maintenance tasks, home improvement services, respite care, social day care, social transportation, home delivered meals, and moving assistance).

A LTHHCP will be available only in social services districts where there are such programs authorized by New York State Department of Health.

(D) Who Can Be Served?

(1) By the Long Term Home Health Care Program

A Long Term Home Health Care Program is a coordinated plan of care and service provided at home to invalid, infirm or disabled persons who are medically eligible for placement in a skilled nursing facility or health related facility, as determined by the New York State Department of Health Form DMS-1 or its successor.

In addition to medical eligibility, the cost of the total expenditure for health and medical services called for in the comprehensive plan or care may not exceed an annual cap.

NOTE

See the Administrative Directive, 83 ADM-74, "Implementation of Chapter 895 of the Laws of 1977" and Chapter 636 of the "Laws of 1980: Long Term Home Health Care Program," dated December 30, 1983 for more details on the LTHHCP.

(2) In the Adult Care Facilities

As previously stated, an adult care facility resident served by the LTHHCP must be medically eligible for placement in a skilled nursing or healthrelated facility and require the services of a LTHHCP. The individual must also meet the admission and retention criteria established for the type of ACF in which the person is residing.

The criteria for admission and retention for each type of adult care facility, except shelters for adults, is attached. Although primarily concerned with the health and functional abilities of individuals, the criteria also reflect the different settings and services offered by each type of facility. Therefore, despite the similarity, the criteria for each type of facility is different from the others, a fact that districts and LTHHCP providers must consider when determining LTHHCP service eligibility.

It is important to note that the ACF operator has primary responsibility for determining the appropriateness of individuals for admission and retention, and for identifying individuals for whom community-based home care services may be appropriate. The ACF operator also retains responsibility for decisions about the ongoing ability of facility staff and services to meet resident needs.

Frequently, residents deemed appropriate for residential health care facility placement can only be retained in an ACF if the residents' care needs can adequately be met, or while the facility operator makes persistent efforts to secure appropriate alternative placement. A DMS-1 score of over 60, or any other indicator developed by the Department of Health, establishing medical eligibility for RHCF admission does not in itself preclude the retention of a resident in the ACF setting. We have

included a case study as Attachment G as an example of the type of client who might be appropriate for this program.

Persistent effort on the part of the facility operator includes assisting the resident or resident's representative with filing five applications with appropriate facilities, telephone follow-up every two weeks and appeal of rejections. The operator must regularly inform the Department of and document both the undertaking and outcome of such efforts.

(E) Expenditure Limitations and Budgeting

Historically, the LTHHCP has been available only to clients whose expenditures for health and medical services called for in the plan of care do not exceed 75% of the cost of care in either a skilled nursing facility (SNF) or a Health Related Facility (HRF) in the district, whichever is the appropriate level of care for the individual. Chapter 854 recognizes that a significant portion of the service normally required in an individual's home is provided by ACF staff. Expenditures for LTHHCP services are, therefore, limited to 50% of the cost of care in an SNF/HRF to a resident of an ACF. The 50% cost cap applies only to those services provided by the LTHHCP. It must not include services determined to be the responsibility of the ACF.

In practice, it may be useful to develop a service plan which reflects the residents assessed service needs, as provided by both the LTHHCP and ACF. The assessors would then delete, from cap consideration, all services determined to be the responsibility of the ACF. The cost of the remaining services would then be compared to the 50% cap. Items which represent unusual expenditures, not normally included in RHCF rates, may be excluded from the budget. These items include such services as kidney dialysis, radiation therapy, chemotherapy, continuous oxygen and the cost of medical transportation to these services.

Annualization and "paper credit" provisions of the LTHHCP do apply to residents of Adult Care Facilities.

Annualization of the budget means that the cost of services can be spread out across a year to show that the yearly cost of services does not exceed the cap.

"Paper credits" are accrued on behalf of a client who uses services in an amount less than the monthly cap.

See 83 ADM-74 pp. 19-21 for a detailed discussion of paper credits and annualized budgets.

(F) Unique Aspects of Providing LTHHCP Services In Adult Care Facilities

In addition to the client meeting the admission and retention requirements, and being eligible for the LTHHCP using a 50% cap, the following requirements are unique to providing LTHHCP services in adult care facilities:

(1) ACF residents are not eligible for LTHHCP services until they have been a resident of one or more Adult Care Facilities for a total of six continuous months (had an admission agreement in effect for at least six months).

(2) Services provided by the LTHHCP must not duplicate or replace those which the ACF is required by law or regulation to provide. Therefore, some service which are available through the LTHHCP should not be authorized for ACF residents. Adult care facilities remain responsible for the provision of room, board, housekeeping' supervision and depending on the type of facility, a certain amount of personal care. Billings to responsible districts, of course, will be made separately for services provided by ACF staff, and for service provided by the LTHHCP. Attachment D provides guidelines for the service responsibility by type of provider.

(3) LTHHCP services to ACF residents must not be initiated prior to the completion of the assessment and authorization of the services by the local social services official. The alternate entry provision, whereby a LTHHCP may accept a client based upon its own assessment, with the joint assessment completed within thirty days, does not apply to this population.

It should be noted that adult care facilities are ideal settings for the use of shared aides should an ACF have more than one resident who requires aide services.

(G) Assessment (1) Elements of the Assessment

Once a resident has been identified as possibly needing LTHHCP services and the resident agrees, the social services district should be contacted to request an assessment of the appropriateness of the use of the LTHHCP.

An important LTHHCP feature is the use of a comprehensive and coordinated assessment process to formulate a summary of the required services and plan of care. Two distinct assessment processes are required: a medical assessment to determine SNF or HRF eligibility, and a home assessment to determine the residents' care needs and the appropriateness of utilizing the LTHHCP.

(a) Medical Assessment - This is the initial assessment process and is accomplished by the completion and scoring of the DMS-1 or its successor. The DMS-1 is the tool that the LTHHCP uses as an indicator of the need for SNF or HRF placement. Once this determination has been made and the physician, resident and ACF operator approve of the use of LTHHCP services for an adult care facility resident, a second assessment process, the home assessment, is authorized by the social services district.

For adult care facility residents the DMS-1 may be completed by the LTHHCP nurse during the home assessment. The ACF operator or facility representative shall make available to the social services district or other authorized assessor pertinent information regarding the health and functional ability of the resident as well as any social and environmental information requested by the assessor related to the facility services being provided to the resident.

(b) Home Assessment - This second assessment is seen as a collaborative effort among the LTHHCP which will be providing services to

the resident, the facility operator and the social service district to determine how, and if, the resident's total health and social care needs can be met in the ACF. It is accomplished by the joint completion of the Home Assessment Abstract or its successor by the nurse representative of the LTHHCP and the professional caseworker from the district in consultation with the ACF operator. The operator or facility representative shall make available to the assessors any pertinent social and environmental information related to the facility services provided to the resident. The social services district will provide the operator of the adult care facility with a copy of the completed assessment, the monthly budget and the care plan. It is from the completed Home Agreement Abstract that a summary of services requirements and a plan of care is developed.

(c) Plan of Care

The plan of care is a document developed by the LTHHCP describing the care to be given to the individual. This plan of care is based on the summary of service requirements and information obtained from the ACF operator and must be based on physicians' orders.

(2) Work Flow (Process)

The following is a listing of the activities which will be associated with the provision of LTHHCP services to adult care facility residents in the order they should normally occur for potential and active Medical Assistance clients.

(a) When a resident requests LTHHCP services, or when the possibility of needing LTHHCP services has been identified, and the resident agrees, the social services district should be contacted to request an assessment of the appropriateness of the LTHHCP.

(b) Representatives of both the LTHHCP and district meet with the operator and then conduct the joint assessment, including the completion of the DMS-1 and Home Assessment Abstract, by talking to the resident or resident representative. A copy of the assessment will be shared with the facility operator.

(c) The LTHHCP obtains physicians' orders for the residents' medical service needs.

(d) A summary of service requirements, based on the joint assessment, the physicians' orders, and consultation with the facility operator is developed, the construction of which is the joint responsibility of the district, the LTHHCP, and when the individual is currently in a hospital or other facility, the discharge coordinator.

(e) Following development of the final summary of service requirements, which list specific kinds and amounts of services to be

provided, a budget review will be initiated by the district. Budget review, in this sense, means a review of the monthly cost of care to determine whether or not the total cost is within 50% of the appropriate monthly average cost for care in a skilled nursing facility, or health related facility, whichever is appropriate. If the district determines that the total yearly expenditures for providing care are not expected to exceed 50% of the yearly cost of care for a skilled nursing or health related facility, the district may authorize LTHHCP services.

(f) Upon completion of the summary of service requirements, and the social services budget determination, the district authorizes services and notifies the LTHHCP to begin providing care. In the event that the district budget determination finds the costs of care exceeding the 50% ceiling on an annual basis, the district continues to be responsible for finding alternative care options.

NOTE: Upon approval or denial of LTHHCP services authorization, a Right to Fair Hearing Notice must be made to the client in accordance with existing regulation and procedures (See Section 0, p.
28 of 83 ADM-74).

(g) District staff and the nurse representative from the LTHHCP retain responsibility for case management as outlined in Sections J and K of Administrative Directive 83 ADM-74. Case management should include the participation of the facility operator who retains responsibility for the care and services which the facility is required to provide.

(H) Case Management Responsibilities

It is important to note that the ACF operator has primary responsibility for determining the appropriateness of individuals for ACF admission and retention and for identifying individuals appropriate for community-based home care service referral. For those individuals judged appropriate for community based service referral, case management is an important factor in determining the roles of the parties involved in the provision of care. Within this context it is expected that ACFs and LTHHCPs will work closely to coordinate their respective services to individual residents. This effort is intended to supplement, not supplant, those case management services provided by the LTHHCP program and the district.

Coordination by the adult care facility operator should include participation in the assessment and reassessment as well as regular discussions between the resident and

the LTHHCP representative. This coordination is important for many reasons. The adult care facility operator can provide information concerning facility operation and services such as meal and activity scheduling and important information on the residents' needs as well as the facility's ability to meet those needs which must be considered in developing the plan of care. On reassessment, the operator's input will be important in evaluating the effectiveness of the plan of care.

The case management responsibilities for the three parties (District, ACF, DrHHCP) involved in the process of determining the extent to which LTHHCP service can appropriately be delivered to ACF residents are best understood when examined against a functional definition of case management. The functions included in that definition: Intake and Screening; Assessment and Reassessment; Comprehensive Service Planning; Service Acquisition; and, Monitoring and Follow-up.

Case Management Responsibilities Specific to the Provision of LTHHCP Services in Adult Care Facilities

	ACF	LTHHCP	District
1. Intake/Screening	Primary responsibility for identifying appropriate referrals.	Minor role	Minor role
2. Assessment and Reassessment	Minor role	Major responsibility shared by LTHHCP and LOSS.	
3. Comprehensive Services Planning	Responsibility shared by all three parties. This is where the plan of care is developed.		

4. Service Acquisition Minor Role	Minor role in the acquisition of LTHHCP services.	Primary for the LTHHCP services provided.	responsibility
5. Monitoring and Follow-up of client, and discharge planning.	Primary responsible for 24 hr monitoring for those Primarily for deliver; and for health status. reassessment, and	responsibility services they ensuring timely	Primarily responsible for for ensuring expenditures are within the caps.

IV. **REQUIRED ACTION**

(A) Districts served by Long Term Home Health Care Programs are required to make this service action available.

Date August 24, 1990

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(B) The Commissioner of the Department of Social Services must submit an interim report to the Governor and the legislature on or before December 31, 1990. The report must include, but need not be limited to, an evaluation of the implementation of the provisions of this act containing the number and types of residents served, cost savings, estimate of future savings and recommendations for continued provisions of long term home health care program services to residents in adult care facilities, other than shelters for adults, subsequent to the expiration of the statute on March 31, 1993.

For this purpose we are asking that social services districts keep track of LTHHCP residents in adult care facilities and complete the attached form entitled "LTHHCP Clients in Adult Care Facilities" (Attachment F). The form should be completed when the resident begins receiving LTHHCP services and again when the resident stops receiving LTHHCP services in the ACF. The district need only complete the Name, MA I.D.#, Provider name, County, and date LTHHCP services ended when completing the form for residents whose services have been terminated. Copies of the form should be sent to both:

Mr. Al Roberts
New York State Department of Social Services
Division of Medical Assistance

Bureau of Long Term Care
40 North Pearl Street
Albany, NY 12243

Mr. Frank Rose
New York State Department of Social Services
Division of Adult Services
40 North Pearl Street
Albany, NY 12243

(C) Since family type homes for adults (FDHA's) are directly supervised by the district, staff have specific roles in assessing and referring residents to the LTHHCP and maintaining required records. District staff must inform FTHA operators of the availability of the LTHHCP to assist residents of their homes who may need the services. Examples of residents who might require LTHHCP services include those returning to the FTHA from an acute care stay in a hospital who will need LTHHCP services while recuperating, those whose health deteriorates while in the FTHA who may need services while recuperating or while awaiting placement to a higher level of care, and those residents with chronic conditions who may need services to assure their continued appropriateness for family-type home care.

(1) During the required semi-annual inspection visit to each FTHA, adult services casework staff through their observations and/or discussions with the operator may become aware of residents who need LTHHCP services, or operators may contact the district directly to request assistance. The procedures governing the work flow process outlined in Section III (G)(2) of this directive must then be initiated to assess the resident's eligibility for the LTHHCP.

(2) For residents in FTHA's who are receiving LTHHCP services, the district shall maintain individual case records containing the completed resident assessment, plan of care and monthly budget. The district must also maintain a log of all residents in FDHA's who are referred for LTHHCP services. The log shall contain the resident's name, social security and MA identification number, FTHA name and address, date of admission to the FTHA, date of application for health services, date and outcome of the assessment and, if services are being provided, the date services were begun and the date services terminated.

(D) Since this is a program expansion there may be confusion or misunderstandings about its use. The social services district may become aware of

instances where LTHHCP services appear to be used inappropriately in ACF settings.

Should a social services district question practices of a LTHHCP in serving ACF residents they should contact the LTHHCP and attempt to resolve the issue. If no resolution can be reached at the local level, Districts should contact their State Social Service's MA representative.

Should a social services district identify problems within the ACF regarding the use of LTHHCP services to duplicate or replace services required of the ACF; the provision of resident care; the presence of inappropriate residents; access to facilities or residents; lack of operator cooperation; an unusual number of referrals or a significant number of inappropriate/unfounded referrals, districts should contact the Regional Office Director of the appropriate Division of Adult Services Regional Office listed below:

Ms. Mary Hart
Eastern Regional Office
488 Broadway
Third Floor
Albany, NY 12243
Telephone: (518) 432-2873

Ms. Sylvia King
Western Regional Office
259 Monroe Avenue
Rochester, NY 14607
Telephone: (716) 238-8185
Toll Free: 1-800-462-6443

Mr. Carlton Reo
Long Island Regional Office
1 Old Country Road
Drawer #61, Suite #480
Carle Place, NY 11515
Telephone: (516) 294-2877

Ms. Erika Teutsch
Metropolitan Regional Office
80 Maiden Lane
New York, NY 10038
Telephone: (212) 804-1234

V. EFFECTIVE DATE

This Administrative Directive is effective upon release; however, the provisions are retroactive to April 1, 1988, the date noted in the Informational Letter (88 INF-20) on the same subject.

_____

Jo-Ann A. Costantino
Deputy Commissioner
Division of Medical Assistance

Judith Berek
Deputy Commissioner
Division of Adult Services

ATTACHMENT 1

LIST OF ATTACHMENTS

(A) A copy of the regulations implementing Chapter 854 of the Laws of 1987. (Not available on-line)

(B) A listing of the LTHHCP/ACF expenditure caps, for each district, set at 50% of the average skilled nursing and health facility rates. (Not available on-line)

(C) A copy of the Facility Directive the Division of Adult Services has sent to adult care facility operators. (Not available on-line)

(D) A chart delineating service responsibility by type of provider. (Not available on-line)

(E) Admission and Retention criteria. (Not available on-line)

(F) A copy of the reporting form "LTHHCP Client in Adult Care Facilities". (Available on-line)

(G) Sample case. (Available on-line)

Note- attachments not included

INFORMATIONAL LETTER

TRANSMITTAL: 95 INF-10

DIVISION: Office of Housing & Adult Services

TO: Commissioners of Social Services

DATE: March 30, 1995

SUBJECT: Protective Services for Adults (PSA): Model Protocol Concerning the Working Relationship Between Police and PSA

SUGGESTED DISTRIBUTION:
Directors of Services
Adult Services Staff
Agency Attorneys
Staff Development Coordinators

CONTACT PERSON: Your district's Adult Services Representative as follows:

Irv Abelman	(212) 383-1755	or USER ID 0AM020
Thomas Burton	(518) 432-2987	or USER ID AX2510
Kathleen Crowe	(518) 432-2985	or USER ID ROF017
Michael Monahan	(518) 432-2667	or USER ID AY3860
Janet Morrissey	(518) 432-2984	or USER ID OPM100

ATTACHMENTS: Model Protocol Concerning the Working Relationship Between Police and PSA (Available On-line)

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
		457	Article 9-B Penal Law (Various Sections)		95 LCM-6

The purpose of this release is to inform local social services districts of a model protocol concerning the working relationship between police and Protective Services for Adults (PSA). This protocol was developed by the Department in conjunction with the Division of Criminal Justice Services (DCJS). The document was prepared with the assistance of a workgroup of the Adult Services Committee of the New York Public Welfare Association and the Department's Law Enforcement Advisory Board, which included representatives from police departments, district attorneys' offices and social services districts. A draft version of this protocol was sent to all Directors of Services for their review and comment.

The development of a model protocol is part of this Department's initiative to improve the coordination between police and PSA staff in responding to situations involving the abuse, neglect and/or exploitation of elderly and other impaired adults who are living in the community. In December 1994, the Department distributed a video and accompanying booklet entitled "Police and Protective Services for Adults: A Partnership" to local districts and over 600 police agencies in New York State. We hope that the use of the this video has improved awareness of adult abuse and neglect and has enhanced the cooperative working relationship between police and PSA. The model protocol is intended as a follow-up to these initial efforts. It provides specific guidelines concerning police and PSA response to vulnerable adults in need of protection. The protocol covers the following topics:

* definitions of adult abuse, descriptions of specific crimes involved in adult abuse cases, and courts of jurisdiction; * the referral process between each agency;

* a joint intervention protocol for responding to referrals which involve allegations of abuse, including contact, assessment and follow-up actions; * information sharing; and

* an appendix containing interview procedures and adult abuse indicators.

Copies of the model protocol also are being sent to police departments throughout the state by DCJS. We recommend that PSA staff contact the police agencies in their community to discuss the model protocol and to develop cooperative working procedures concerning the provision of services to impaired adults who are victims of abuse, neglect and exploitation. Also, if you would like technical assistance on the implementation of this protocol, please call your adult services representative.

Peter R. Brest
Associate Commissioner

MODEL PROTOCOL CONCERNING THE WORKING RELATIONSHIP BETWEEN POLICE AND PROTECTIVE SERVICES FOR ADULTS

RATIONALE

In recent years, there has been a dramatic growth in the number of frail elderly and other mentally or physically impaired persons who are living in the community, rather than in institutions. Because of their impairments, these individuals are vulnerable to abuse and exploitation, whether by family members, caregivers or others. Additionally, impaired adults may neglect their own basic needs because they are unable to obtain adequate food, clothing, shelter, medical care or entitlements on their own behalf. Local social service departments have the primary responsibility under the Protective Services for Adults (PSA) program to provide services to impaired adults who are abused, neglected or exploited by others or who are neglecting their own needs. In providing services to these individuals, PSA may need to obtain assistance from law enforcement agencies to ensure that these vulnerable adults are protected. Police agencies may need to refer to PSA when they discover impaired adults in need of community services. This protocol contains guidelines for establishing an effective working relationship between both parties.

I. DEFINITIONS

A. ADULT ABUSE

Adult Abuse is defined as the physical, sexual, emotional or financial abuse and/or neglect of a physically or mentally impaired adult 18 years of age or older who is residing in the community, by another individual, when the impaired adult is unable to provide for his/her own health, welfare and safety. Types of abuse include:

Physical Abuse: non-accidental use of force that results in bodily injury, pain or impairment (e.g. slapped, burned, cut, bruised, improperly physically restrained). Sexual Abuse: non-consensual sexual contact of any kind.

Emotional Abuse: the willful infliction of mental anguish, e.g. the victim may be frightened, threatened, humiliated, intimidated, isolated, called names, treated as a child, etc.

Financial Abuse: the illegal or improper use and/or exploitation of funds, property or other resources (e.g. theft, fraud, embezzlement, conspiracy, forgery, falsifying records, coerced property transfers or denial of access to assets).

Neglect (by others) the refusal or failure to fulfill a caretaking obligation, e.g. abandonment, failure to provide food, denial of medical service,etc. It may be active (willful) or

passive (due to inadequate caregiver knowledge or infirmity).

B. OFFENSES

MAJOR CLASSES OF OFFENSES THAT MAY BE PROSECUTED IN NEW YORK STATE:

1. A violation is not a crime but an offense carrying the lowest sanctions. The maximum term of imprisonment for a violation is 15 days.

2. A misdemeanor is the least serious crime. A class A misdemeanor carries a maximum sentence of one year in a local jail or 3 years on probation. A class B misdemeanor carries a maximum sentence of three months in a local jail or one year on probation.

3. A felony is defined as a crime for which one can receive a sentence in excess of one year in a state correctional facility or 5 years on probation. Felonies are divided into five classes ranging from A, the most serious, to E.

C. SPECIFIC CRIMES

Following is a list of some criminal acts that may typically be present in adult abuse situations:

1. Larceny: A person steals property and commits larceny when, with intent to deprive another of property or to appropriate the same to himself or to a third person, he wrongfully takes, obtains or withholds such property from an owner thereof. The act is elevated to specific offense levels depending upon the type of property taken or the manner in which it is taken. See Penal Law (PL) 155.05 (1) and PL Article 155 generally.

2. Extortion: A person obtains property by extortion when he compels or induces another person to deliver such property to himself or to a third person by means of instilling in him a fear that, if the property is not so delivered, the actor or another will engage in certain injurious conduct. Note that the wrongful taking, obtaining, or withholding of another's property by extortion is considered larceny in New York State. See PL 155.05(2)(e).

3. Forgery: A person is guilty of forgery in the third degree when, with intent to defraud, deceive or injure another, he falsely makes, completes or alters a written instrument. The act is elevated to a first or second degree offense depending upon the type of written instrument involved. See PL Article 170 generally.

4. Coercion: A person is guilty of coercion in the second degree when he compels or induces a person to engage in conduct which the latter has a legal right to abstain from engaging in, or to abstain from engaging in conduct in which he has a legal right to engage, by means of instilling in him a fear that if the demand is not complied with, the actor or another will engage in certain injurious conduct. The act is elevated to a first degree offense depending upon the type of injurious conduct involved. See PL 135.60 and 135.65.

5. Scheme to Defraud: A person is guilty of a scheme to defraud in the second degree when he engages in a scheme constituting a systematic ongoing course of conduct with intent to defraud more than one person or to obtain property or an existing, canceled or revoked access device, from more than one person by false or fraudulent pretenses, representations or promises and so obtains such property or device from one or more of such persons. Note that the act is elevated to a first degree offense when there is an intent to defraud or obtain items from ten or more persons. See PL 190.60 and 190.65.

6. Harassment: A person is guilty of harassment in the second degree when, with intent to harass, annoy or alarm another person , he or she strikes, shoves, kicks or otherwise subjects such other person to physical contact, or attempts or threatens to do the same; or follows that person in or about public place(s); or engages in a course of conduct or repeatedly commits acts which alarm or seriously annoy such other person and which serve no legitimate purpose. Note that the act is elevated to a first degree offense when he or she repeatedly harasses another or repeatedly commits acts which places such person in reasonable fear of physical injury. See PL 240.25 and 240.26.

7. Menacing: A person is guilty of menacing in the third degree when, by physical menace, he or she intentionally places or attempts to place another person in fear of death, imminent serious physical injury or physical injury. The act is elevated to a first or second degree offense depending upon the circumstances under which the offense is committed or upon the number of previous convictions for such offense. See PL 120.13, and 120.15.

8. Assault: A person is guilty of assault in the third degree when with intent to cause physical injury to another person, he causes such injury to such person or to a third person; or he recklessly causes physical injury to another person or with criminal negligence, he causes physical injury to another person by means of a deadly weapon or a dangerous instrument. The act is elevated to a first or second degree offense depending upon the circumstances under which the offense is committed. See PL 120.00, 120.05 and 120.10.

9. Sex Offenses: A person is guilty of committing a sex offense when such person engages in unlawful sexual activity of a non-consensual nature or where one of the participants is less than the prescribed statutory age of consent. Such offenses include, but are not limited to rape, sodomy and sexual abuse. See PL Article 130 generally.

10. Criminal Contempt: A person is guilty of criminal contempt in the second degree when such individual engages in conduct which disturbs, interrupts, impairs, etc, the lawful court process or other mandate of a court. The act is elevated to a first degree offense under specified circumstances, including when a duly served order of protection is violated. See PL 215.50 and 215.51.

11. Endangering the Welfare of an Incompetent Person: A person is guilty of endangering the welfare of an incompetent person when he knowingly acts in a manner likely to be injurious to the physical, mental or moral welfare of a person who is unable to care for himself because of mental disease or defect. See PL 260.25.

12. Reckless Endangerment: A person is guilty of reckless endangerment in the second degree when he recklessly engages in conduct which creates a substantial risk of serious physical injury to another person. The act is elevated to a first degree offense when under circumstances evincing a depraved indifference to human life, he recklessly engages in conduct which creates a grave risk of death to another person. See PL 120.20 and 120.25.

13. Unlawful Imprisonment: A person is guilty of unlawful imprisonment inthe second degree when he restrains another person. Pursuant to law, "restrain" means to restrict a person's movements intentionally and unlawfully in such manner as to interfere substantially with his liberty by moving him from one place to another or by confining him either in the place where the restriction commences or in a place to which he has been moved, without consent and with knowledge that the restriction is unlawful. Note the the act is elevated to a first degree offense when the actor restrains another person under circumstances which expose the latter to a risk of serious physical injury. See PL 135.05 and 135.10.

D. COURTS OF JURISDICTION

Situations involving adult abuse and/or neglect involving family or household members may be pursued in either criminal or family court. The family court and the criminal courts have concurrent jurisdiction over all family offenses unless the offender would not be criminally responsible by reason of age (handled exclusively by family court, except that persons age 14-15 designated as juvenile offenders can be prosecuted in criminal court for various juvenile offender offenses). Family offenses include acts which would constitute disorderly conduct, harassment in the first and second degree, menacing in the second and third degree, reckless endangerment, assault in the the second and third degrees, or attempted assault between spouses or former spouses, or between parent and child or between members of the same family or household.

The criminal courts of New York State are comprised of superior courts, i.e. supreme or county courts, and the local criminal courts including district, city, town or village courts. The Family Court is a statewide court which has one branch in each of the State's 62 counties. The Family Court proceeding is a civil proceeding and is for the purpose of attempting to stop violence, ending the family disruption and obtaining protection. Proceedings in family court are normally closed to the public and will not result in a criminal record. The proceeding in the criminal courts is for the purpose of prosecuting the offender and can result in criminal conviction of the offender.

II. REFERRAL PROCEDURES

A. PSA TO POLICE AGENCIES

PSA will refer to police agencies in the following circumstances:

1. To implement court orders such as ACCESS or the Short Term Involuntary Protective Services Order (STIPSO), to request assistance in enforcing Orders of Protection, or to request assistance in gaining access.

2. To report a crime and request an investigation be commenced.
3. To request assistance in protecting clients who are presenting a danger to themselves or others.

4. To provide protection for the caseworker if there is reason to suspect physical danger from the client or caregiver. B. POLICE AGENCIES TO PSA

Police agencies should refer to PSA in the following situations.

1. To obtain services for impaired persons living in the community who appear to be at risk of harm and unable to protect themselves.

2. To request assistance with the investigation of alleged crimes against impaired elderly or disabled persons, who have no one else willing and able to assist them.

3. To request information or advice when questionable situations concerning elderly or disabled adults occur. III. REFERRAL RESPONSE

A. POLICE TO PSA

Upon receipt of a PSA referral from law enforcement, the PSA Intake Worker will determine whether to accept or reject the case for a PSA assessment or request additional information as needed. If additional information is needed which is pertinent to the client's potential eligibility for PSA, the PSA intake worker will request information from appropriate sources to enable a decision to be made as to whether the case will be accepted for a PSA assessment. In any case, a decision will be made whether to accept the case for assessment within 24 hours after the referral is received. If, on the basis of information supplied and any additional information obtained by the intake worker, it appears that the client may be eligible for PSA, the case must be accepted for assessment. If a case is not accepted for assessment, PSA will inform the referral source orally or in writing within 15 calendar days of its decision. A case will be rejected for assessment only if PSA eligibility can be conclusively ruled out. If any doubt remains about a person's PSA eligibility, the case will be accepted for assessment.

Upon acceptance of a referral for PSA assessment, the assigned PSA caseworker will visit the referred individual within three working days of the date the referral was received (or 24 hours if the situation is life threatening) in accordance with 18 NYCRR 457.1 (c)(2) of New York State Department of Social Services (NYSDSS) regulations. In accordance with 18 NYCRR 457.14, PSA will inform the referral source orally or in writing of the person's eligibility or ineligibility for PSA within 15 calendar days of the completion of the PSA assessment.

B. PSA TO POLICE

Upon receipt of a request from PSA for law enforcement assistance, the police agency will respond and investigate the situation according to established procedures. Depending on the nature of the referral, this may include utilizing emergency entry procedures, providing emergency care, or defusing and stabilizing the immediate situation. In cases of suspected abuse or crimes, the police officer will identify the victim, suspects and witnesses, preserve the crime scene, and obtain preliminary statements of

the victim and witnesses, according to established procedures. Efforts will be made to coordinate actions with PSA and to provide follow-up activities as needed.

IV. JOINT INTERVENTION PROTOCOL FOR ALLEGATIONS OF ABUSE:

A. In situations when it is suspected that a crime may have been committed against an impaired adult, PSA will contact the appropriate law enforcement agency to discuss whether a joint intervention is appropriate. The primary purposes of the joint intervention are to provide protection to the victim and to utilize law enforcement options that may be available.

To ensure a successful outcome, PSA and law enforcement agencies agree to work cooperatively and to develop intervention strategies in accordance with the respective roles of each agency. If a joint response is determined appropriate, the following guidelines will be followed:

1. The PSA caseworker and law enforcement officer will discuss the referral or incident information and determine what role each individual will play in the investigation. Information will be shared in accordance with confidentiality requirements of both agencies to facilitate the investigation. Decisions will be reached on who will be contacted (referral sources, victim, witnesses, alleged perpetrator), and where contacts will occur (home, office, police station, other protected setting).

2. Both agencies agree that adults have basic rights to self-determination. A competent adult has the right to exercise free choice in making decisions. The competent adult abuse victim, unlike a child abuse victim, has the right to refuse services and assistance. However, if it appears that the adult is incapable of making decisions on his or her own behalf, because of an impairment, then the situation should be investigated and appropriate action taken to protect the adult, pending the determination of decision-making ability. (Determinations of decision-making capacity may require a mental health assessment or eventual court involvement).

3. PSA casework staff will assess the nature of the adult's impairment, the risks that are present, the adult's ability to deal with the situation and willingness to accept assistance from others. The caseworker will arrange for the assessment of any medical or psychological problems which may affect the adult's ability to participate fully in the interview process. PSA staff will assess the adult's need for medical care, services or other resources in the community, including the need for emergency relocation to a protected setting.

4. Law enforcement staff will determine whether a crime has been committed against the impaired adult. They will preserve the crime scene (which may include photographing evidence, injuries or conditions), obtain preliminary statements of the victim and witnesses and identify specific violations.

B. CONTACT AND ASSESSMENT

1. The interview will be conducted in accordance with the information ncontained in APPENDIX A,"INTERVIEW PROCEDURES".

2. The assessment of possible abuse and/or criminal actions should be conducted using the information contained in APPENDIX B, "INDICATORS OF ABUSE".(Adapted from material prepared by the Police Executive Research Forum).

C. FOLLOW UP ACTIONS:

1. Following the initial response, decisions must be made as to the appropriate courses of action. Referrals for services, legal interventions, medical treatment and protected placement should be made as quickly as possible.

2. PSA will assist in locating emergency housing, arrange for any necessary medical or mental health assessments, refer for community services such as substance abuse services or other needed counseling for the victim, offender or family members. If necessary, PSA will pursue legal interventions such as Orders of Protection, Guardianship or other legal interventions. PSA will continue to provide case management services as needed.

3. Law enforcement may file charges if there is reasonable cause to believe a crime has been committed. They may arrest the alleged perpetrator depending on the seriousness of the crime, when it is necessary to preserve the peace, if the alleged offender presents a danger to others, or if there is reason to believe that the alleged offender will flee. Where a police officer has reasonable cause to believe that a felony has been committed against a member of the same family or household, or that a person has committed an act in violation of a "stay away" provision of a duly served order of protection or has committed a family offense in violation of such order of protection, the officer will arrest the person and will not attempt to reconcile the parties or mediate.

Where a police officer has reasonable cause to believe that an individual has committed a misdemeanor against a victim or has committed a petty offense in the officer's presence, the officer shall arrest the offender, unless the complainant requests otherwise. The officer is prohibited from asking the victim whether or not there should be an arrest. If the officer suspects that the victim has been threatened, coerced, is in immediate danger or is incapable of making informed decisions, the officer has the discretion to arrest without the victim's complaint, providing there is probable cause to effect said arrest. As soon as possible after an arrest, a sworn statement or deposition is to be taken from the complainant. The arrest report will serve as the crime report, depending on departmental policy.

There is no requirement that a crime (felony or misdemeanor) occur in the officer's presence. Consequently, a lawful arrest may be and often shall be founded upon factors other than the officer's observations, including but not limited to physical injury, property damage, signs of serious visible disruption and/or statements by the victim or other witnesses.

Law enforcement will evaluate the likely effects and propriety of the arrest. When the cause for abuse is determined to result from a correctable

shortcoming of the caregiver, and arrest is not required according to the conditions outlined above or by departmental policy, the preferred resolution may include education, counseling, or supplemental support or resources rather than arrest of the caregiver.

4. If considered appropriate, based on a joint decision of police, prosecutors, PSA staff and the victim (if the victim retains decision-making ability) the case will be presented to the court. PSA staff and law enforcement will cooperate in the presentation and follow through on the case.

V. INFORMATION SHARING

A. Both entities agree to share that information concerning the referred person which is necessary to conduct investigations and deliver services, to the extent permitted by applicable laws and regulations including 18 NYCRR Part 357 of NYSDSS regulations. Additional information regarding confidentiality issues is contained in a NYSDSS transmittal 92 INF-26 entitled "PSA: Confidentiality /Information Sharing." Information may be disclosed where such disclosure is reasonably necessary to assess an individual or provide protective services to an individual.

B. Both entities agree to orient their staff concerning the implementation of these working procedures.

APPENDIX A

I. INTERVIEW PROCEDURES:

A. PREPARATION FOR INTERVIEW

1. As indicated in Section IV, A, of these procedures, police and PSA staff will work out cooperative arrangements to prepare for joint interviews.

2. Before beginning the interview, obtain as much information as possible about the client and the alleged abuse from collateral sources or existing records. Determine if there are medical or psychological problems which would impede the interview process. Examples of barriers could include hearing, vocal or vision impairments, mobility restrictions, cognitive impairments, confusion, memory loss, mental illness.

3. If the referral indicates that language may be a barrier to intervention, PSA and law enforcement will cooperate in efforts to find an individual who shares a common language with the victim. This person should preferably be a neutral party, without family or household ties to the victim.

4. The adult's level of intellectual functioning should be considered when choosing words and descriptions.

5. Individuals will need to be interviewed separately, away from the alleged abuser. It may be necessary to move the client to a neutral location if the client is willing and able.

6. Investigators should respect the victim's dignity and keep the number of persons present during sensitive interviews to a minimum. It is usually difficult for elderly or impaired persons who have been abused to admit their vulnerability, particularly when the abuser is a family member or loved-one, or when sexual abuse is alleged. Every effort should be made by police and PSA to coordinate investigations, thereby eliminating multiple, stressful and embarrassing interviews.

B. GENERAL INTERVIEW GUIDELINES

1. Interviewers should try to be introduced by a trusted or concerned relative/friend. Try to establish rapport with the interviewee. Begin the interview with questions that are open-ended. Questions must be nonsuggestive and non-leading. As the interview proceeds, questions can be more focused and detailed. Specific questions should include "who, when, where, how often".

2. For non-verbal adults, attempt written communication or obtain special translator assistance.

3. Allow the adult to tell his/her own story, at his/her own pace.

4. When interviewing family member or caregiver, observe whether they appear fearful or hesitant in their responses, or if they try to blame the victim. Notice if they appear concerned about the client's general wellbeing. Evaluate the nature of those concerns. Assess whether information provided by the client during the interview conflicts with information provided by the family member or caregiver.

C. INTERVIEW PROCEDURES

1. The PSA caseworker should assess the client's activities of daily living(ADL's) by asking the client to describe a typical day. Assess client's coping skills and their degree of dependence on others for financial, psychological and emotional support. Inform the client of their rights. Allow the client to ask questions and offer them emotional support.

2. If the client does disclose abuse or neglect, the interviewer should refrain from sharing his or her emotions. However it is appropriate to validate the client's emotions and to explore the client's feelings about the abuse and the offender. Some elderly or impaired adults are reluctant to report abuse for fear of automatic removal to an institution. Victims who have reported abuse must be reassured that legal remedies and removal procedures are not automatically invoked, but only when determined to be necessary as a result of a joint police and PSA investigation, in which the victim's needs and desires are given priority.

3. Role of Police: Whenever caregivers or other persons are determined to be suspects in an abuse case or other criminal matter, they must be advised of their constitutional rights before any further questioning takes place. Explore possible explanations for allegations, suspicious activity, evidence, injuries to victims, living conditions and behavior of the victim. Determine the existence of any other victims, witnesses or suspects and the relationships that may exist among all parties. Determine if the suspect had the opportunity and access to the victim necessary to commit the alleged acts. Written statements should be obtained, consistent with department policy. If available, video and audio equipment may be employed.

D. INTERVIEW FOLLOW-UP

1. Pursue any appropriate referrals for service, legal interventions (i.e. restraining order, protective placement) and medical assessment/treatment.

2. Seek out corroborating information relating to allegations of wrong doing as well as the details of the victim, witness and suspect statements. Investigative resources that may prove to corroborate information include:

a. Statements of other knowledgeable persons involved (friends, neighbors, family, clergy, physician, attorney, banker, etc., observing privileged communication statutes as applicable.)

b. Physical evidence

c. Opportunity and access

d. Medical history and examinations, pharmaceutical (victim)

e. Employment history or criminal history of the suspect

f. Agency records(health, social services, zoning, mental health)

g. Individual certification (professional caregivers)

h. Real property, financial or bank records (transfers, ownership changes)

i. Legal records (power of attorney, guardianship, living wills, health care proxies)

ADULT ABUSE INDICATORS

PHYSICAL EVIDENCE. When a crime scene exists, it should be photographed and processed as any major crime. Areas to be considered include:

a. Condition of the victim or wounds (medical examination of the victim, for old and recent injuries or evidence of sexual assault may be warranted);

NOTE: It may be necessary for the officer to arrange for non emergency transportation to a medical facility for an evidentiary medical examination.

b. Weapons, restraints or instruments causing injuries
c. Living conditions/health and safety hazards (kitchen, bedroom, bath)
d. Clothing, bedding and towels
e. Biological evidence (body fluids, food samples)
f. Sexual aids, pornographic materials
g. Personal papers (letters, telephone/address books, bank and financial statements, computer files and disks, and legal documents) belonging to the victim and the suspect(s).

TYPICAL SIGNS AND SYMPTOMS. There are no definitive profiles of victims or abusers. There are, however, factors that officers should look for in abuse cases. The following factors may be of value in identifying at-risk relationships, which when observed in conjunction with indicators of abuse, should trigger further investigation.

a. PERSONALITY TRAITS OF ABUSERS. These may include emotional problems, drug and alcohol abuse or previous psychiatric hospitalization.

b. TRANSGENERATIONAL FAMILY VIOLENCE. A history of domestic violence (elder, spousal or child abuse).

c. WEB OF DEPENDENCY. A poor relationship between an elderly or impaired person and a caregiver, dependency of a caregiver on an elderly or impaired person, bad temperament or hostility by an elderly or impaired person or caregiver, resentment, or a caregiver's frustration resulting from an elderly or impaired person's increased dependency for emotional, physical and financial support may lead to abuse.

d. SOCIAL ISOLATION. Aging and reduced mobility are often accompanied by loss of contact by friends, family and the outside world. This isolation can hide the effects of violence, exploitation, neglect and very often self-neglect.

e. PHYSICAL ISOLATION. Confinement to one's room or bed. Inappropriate physical restraint or being left alone for long periods.

f. INTERNAL AND EXTERNAL STRESSORS. Abusive relations between caregivers and elderly or impaired victims are often inflamed by economic difficulties, marital conflicts, deaths and illnesses of close friends or relatives, and other stressors. In some cases, caregivers may be elderly or impaired persons themselves. Some middle-aged caregivers may be

providing care and/or support to their children as well as their parents. Caregivers who are over-extended, unaware of outside resources and find themselves unable to cope with overwhelming responsibilities, may resort to neglect or abuse.

INDICATIONS OF ADULT ABUSE

a. INDICATORS OF PHYSICAL ABUSE. Elderly or impaired persons may frequently exhibit signs of falls and accidents. These same signs may be indicators of physical abuse, especially when victims or suspects attempt to conceal their presence or other inconsistent or irrational excuses for injuries. Investigators should consider the presence of any injury in their assessment of physical abuse cases. The following injuries are examples of indicators of abuse and should be considered together with an assessment of the abuser/victim relationship and other observations:

- Bruises or welts
- in the shape of articles such as belts, buckles, electric cords, or other definite shapes or patterns - discoloration causing bilateral stripes on upper arms, or clustered on other body parts.

- Burns
- caused by cigarettes, caustics, hot objects
- friction from ropes, chains or other physical restraints

- Other injuries or conditions
- fractures, sprains, lacerations and abrasions
- injuries caused by biting, cutting, poking, punching, whipping or twisting of limbs
- disorientation, stupor or other effects of deliberate over-medication

- Multiple injuries
- in various stages of healing

b. BEHAVIORAL INDICATORS OF PHYSICAL ABUSE (VICTIM). Indications of abuse are not limited to visible wounds or injuries. The behavior of victims can reflect traits often associated with adult abuse. Presence of these indicators is not conclusive and should serve only to direct the focus of further investigation.

- Easily frightened or fearful
- Exhibiting denial
- Agitated or trembling
- Hesitant to talk openly
- Implausible stories
- Confusion or disorientation
- Contradictory statements, not due to mental dysfunction

c. BEHAVIORAL INDICATORS OF PHYSICAL ABUSE (SUSPECT)

Individually none of these indicators or characteristics constitutes evidence of wrongdoing on the part of a relative or caregiver. However, when one or more indicators are present along with injuries and other (victim) behavioral indicators, further investigation is warranted.

- Concealment of victim's injuries
- Inconsistent explanation for victim's injuries
- History of making threats - History of mental problems or institutionalization
- History of substance or alcohol abuse
- Victim of abuse as a child
- Dependent on victim's income or assets
- Demeaning comments about the victim
- Discounting the victim's assertions of cruelty or violence

d. INDICATORS OF SEXUAL ABUSE. Physical indicators of adult sexual abuse should direct investigators to search for other corroborating evidence. Many of these indicators cannot be identified without medical examination. Indicators may include the following:

- Sexually transmitted diseases
- Genital and/or anal infection, irritation, discharges or bleeding, itching, bruising, scarring or pain
- Frequent, unexplained physical illness
- Painful urination and/or defecation
- Urinary retention, constipation or fecal soiling
- Difficulty walking or sitting due to anal or genital pain
- Psychosomatic pain such as stomach or headaches
- Inappropriate sex-role relationship between victim and suspect
- Physical evidence of pornography or prostitution

e. BEHAVIORAL INDICATORS OF SEXUAL ABUSE (VICTIM). The embarrassment of recounting forced sexual activity often results in the refusal of an elderly or impaired adult to report and describe the crime. The following indicators are often present in (but not limited to) cases of sexual abuse:

- Inappropriate, unusual or aggressive sexual behavior
- Self-exposure
- Curiosity about sexual matters - Intense fear reaction to an individual or to people in general
- Extreme upset when changed or bathed
- Self destructive behavior (head-banging, self-biting)
- Anti-social behavior (lying, stealing, verbal aggression)
- Mistrust of others
- Direct or coded disclosure of sexual abuse
- Depression or poor self-esteem
- Eating disturbances (overeating or undereating)
- Fears, phobias, compulsive behavior
- Bedwetting and other regressive behavior
- Sleep disorders (nightmares, fear of sleep, excessive sleeping)

f. BEHAVIORAL INDICATORS OF SEXUAL ABUSE (SUSPECT) An individual who is sexually abusing or exploiting an impaired person he or she is

caring for may take extreme measures to ensure the activity is concealed. This may be exhibited through:

- Overprotectiveness
- Dominance
- Hostility toward others
- Social isolation

g. INDICATORS OF EMOTIONAL ABUSE. There is usually a lack of physical evidence in cases of emotional abuse. Often emotional abuse accompanies other abuse and neglect. Officers should look for:

- Signs of inappropriate confinement or restraint
- Signs of deprivation of food or hygiene

h. BEHAVIORAL INDICATIONS OF EMOTIONAL ABUSE (VICTIM)

Although the presence of the following behavioral indicators may be reflections of abuse, they may also be symptoms of emotional disorders, dementia, or other conditions associated with aging or impairment. Officers must be mindful of this but careful not to arbitrarily attribute these symptoms to aging rather than possible abuse.

- Sleep, eating, or speech disorders
- Depression
- Helplessness or hopelessness
- Isolation
- Fearfulness
- Agitation or anger
- Confusion
- Low self-esteem
- Seeks attention and affection

i. BEHAVIORAL INDICATORS OF EMOTIONAL ABUSE (SUSPECT).

Emotional abuse of an impaired person may stem from the suspect's own low self-esteem and his or her unrealistic expectations of the victim. The suspect may exhibit irrational behavior and,

- Threaten the victim
- Call the victim names
- Speak poorly of the victim
- Treat the victim as an infant
- Use restrictive treatment
- Ignore the victim and his or her needs

j. INDICATORS OF NEGLECT. It is common to observe a combination of indicators when neglect (including self-neglect) exists. Neglect may be found in varying levels and may be recent or long-standing. Care should be taken to photograph and document evidence that will likely change with better care. Indicators of neglect include, but are not limited to:

- Neglected bedsores
- Skin disorders or rashes
- Untreated injuries or medical problems

- Poor hygiene
- Hunger, malnutrition, dehydration
- Pallor, sunken eyes or cheeks
- Inadequate supply of food - Absence of or failure to provide prescribed medication
- Lack of clean bedding or clothing
- Inadequate heating
- Unsanitary or unsafe living conditions
- Lack of required dentures, hearing aides or eyeglasses

NOTE: There are non-criminal influences (poverty, family background/culture, education and ignorance) that may contribute to the appearance of neglect but are consistent with normal living conditions for that impaired person's family. The need for action should be guided by the impaired person's wishes and understanding of consequences and the likelihood of harm if he or she remains in those conditions. This is not to suggest that a caregiver's responsibility to provide adequate care is diminished when these conditions exist. For example, there is a vast difference between infrequent bathing habits and dirty, infected wounds resulting from neglect.

k. BEHAVIORAL INDICATORS OF NEGLECT (VICTIM). Continued neglect or self-neglect may lead to a number of the following behavioral characteristics. Existence of these conditions justify further investigation, but in themselves they do not constitute adequate evidence of neglect.

- Aggressiveness
- Non-responsiveness or helplessness
- Inability to care for self
- Dependent behavior
- Refusal of help
- Self-imposed isolation
- Detachment

l. BEHAVIORAL INDICATORS OF NEGLECT (SUSPECT) When neglect results from the action or lack of action of a caregiver, one or more of the following characteristics may be present:

- Substance or alcohol abuse
- Mental illness
- Developmental disability
- Hostility toward others
- Apathetic/passive/detached/unresponsive
- Depression or irrational behavior
- Lack of concern for the victim
- Lack of necessary skills

m. INDICATORS OF FIDUCIARY ABUSE. As some elderly or impaired persons experience decreased mobility (loss of driving ability and personal mobility), they become dependent on others to assist and sometimes take over their financial matters. Although this increases the opportunity for abusive practices, caregivers and others (lawyers, bankers, etc.) may have a need to conduct legitimate financial

business or handle funds in order to provide care to the person. The presence of the following activities may justify closer examination:

- Unusual volume or type of banking activity/activity inconsistent with victim's ability (e.g. use of ATM by a bedridden victim)
- Excessive concern by another over cost of caring for the victim/reluctance to spend or pay bills
- Recent expressions of interest in a victim who has known assets
- Recent changes in ownership of victim's property
- A will drawn or power of attorney granted to an incompetent victim
- Inappropriate actions by a caregiver in the victim's financial affairs
- A caregiver with no means of support
- Placement, care or possessions of victim inconsistent with victim's estate
- Missing items (silver, art, jewelry)
- Caregiver isolates victim from friends and family

This material is adapted from material prepared by the Police Executive Research Forum, 2300 M Street NW, Suite 910, Washington, DC 20037

99-INF-006 APS Confidential Information Sharing Agreement

OFFICE OF CHILDREN AND FAMILY SERVICES

INFORMATIONAL LETTER	TRANSMITTAL: 99 OCFS INF-6

DIVISION: Development and Prevention Services

TO: Commissioners of Social Services

DATE: April 15, 1999

SUBJECT: Protective Services for Adults (PSA): Confidential Information Sharing Agreement

SUGGESTED DISTRIBUTION: Directors of Social Services
Protective Services for Adults Supervisors
Agency Attorneys

CONTACT PERSONS: Any questions concerning this release should be directed to your district's Adult Services representative as follows:

Kathleen Crowe	(518) 486-3451	or USERID ROF017
Carole Fox	(518) 474-3167	or USERID AX5050
Michael Monahan	(518) 474-9590	or USERID AY3860

ATTACHMENTS: Model PSA/OMH/OMRDD Agreement Concerning Information Sharing (available on line)
Letter of Introduction (not available on line)

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref	Manual	Misc Ref
92 INF-26		Part 357 Part 403 Part 457	473 SSL 20, 34, 136 33.13 MHL Article 27-F of Public Health Law		

I. Purpose

The purpose of this release is to inform local districts of a Confidential Information Sharing Agreement which has been developed by the New York State Office of Children and Family Services (OCFS) in cooperation with the New York State Office of
Mental Health (OMH) and the New York State Office of Mental Retardation and Developmental Disabilities (OMRDD). This agreement, which conforms to the applicable confidentiality laws and regulations of each agency, sets forth the conditions under which confidential information may be disclosed among local district PSA, OMH and OMRDD providers concerning individuals who are being mutually served. Safeguards have been included to ensure that information disclosed will not be used inappropriately by either party and that the confidential nature of the information will be protected.

II. Background

One of the guiding principles of Protective Services for Adults (PSA) is that PSA is a community effort requiring cooperation among a number of agencies. This concept is supported by Section 473.2(a) of the Social Services Law (SSL) which states that: "the effective delivery of protective services for adults requires a network of professional consultants and services providers" and requires local social services districts to work "with other public, private and voluntary agencies including but not limited to health, mental health, aging, legal and law enforcement agencies, for the purpose of assuring maximum local understanding, coordination and cooperative action in the provision of appropriate services" to PSA clients. The SSL therefore anticipates the sharing of information necessary to appropriately serve the client.

Sections 20, 34, 136 and 473 of the Social Services Law, and Section 33.13 of the Mental Hygiene Law (MHL) set forth the standards for maintaining the confidentiality of clinical and case record information. Some local districts have from time to time experienced difficulty obtaining confidential information from agencies licensed by OMH or OMRDD when such information was necessary for the provision of Protective Services for Adults. This hesitancy or refusal to provide information is generally based on a belief that the sharing of such information is legally prohibited despite the fact that both the SSL and MHL allow for the exchange of information between service agencies as set forth in the attached agreement.

This agreement, which has been sanctioned by the commissioners of OCFS, OMH and OMRDD respectively, will assist in facilitating a more cooperative relationship in the appropriate sharing of confidential information. Local districts are urged to contact local mental health and mental retardation and developmental disability service providers in order to sign this agreement and abide by its contents. When accompanied by the letter signed by the OCFS, OMH and OMRDD commissioners, local agencies should feel secure in entering into the agreement with your agency's PSA program. It is anticipated that many of the previously experienced problems in obtaining confidential information will be alleviated through the use of the Agreement.

_____
Donald K. Smith
Deputy Commissioner
Development and Prevention Services

MODEL PSA/OMH/OMRDD AGREEMENT CONCERNING INFORMATION SHARING

I. PURPOSE:

This agreement is between _____, a provider of services to individuals who are diagnosed with, or being assessed for, a mental illness, mental retardation or developmental disability, as defined in section 1.03 of the Mental Hygiene Law, and the _____ County Department of Social Services Protective Services for Adults Program (PSA) as provided for in Section 473 of the Social Services Law. The agreement sets forth the conditions and responsibilities of each service agency for the sharing of confidential information upon the initial referral of an individual from one service agency to the other for the arrangement for and the provision of services, as appropriate, or when an individual is already receiving services from both service agencies and the information is necessary for the coordination and continuation of such services.

All parties to this Agreement recognize that preservation of the confidentiality of information and the protection of an individual's right to privacy and personal autonomy is achieved by restricting access to and disclosure of information maintained by the parties regarding such individual. Both service agencies also recognize, however, that access to certain confidential information concerning an individual is essential for the arranging of necessary services and assuring the continuity and appropriateness of such services. It is further recognized, pursuant to Section 473.2 (a) of Social Services Law, that the effective delivery of PSA requires a network of professional consultants and service providers and that local social services districts are required to plan with other public, private and voluntary agencies, including mental health agencies, for the purpose of assuring maximum local understanding, coordination and cooperative action in the provision of appropriate services. In addition, Section 473-e of the Social Services Law, Section 2782 of the Public Health Law and Section 33.13 of the Mental Hygiene Law provide for the sharing of specific information concerning

persons receiving services among service providers when necessary to assure the provision of essential services to an individual.

II. NATURE OF INFORMATION TO BE DISCLOSED

Information disclosed to either agency must be reasonably related to the purposes for which the information is requested and must be narrowly tailored to only that information essential to assessing an individual's need for, or obtaining or continuing the service(s) being sought or provided. Shared information may not go beyond that which is necessary to ensure the delivery of essential services to the individual. Notwithstanding the provisions of this agreement, a social services official may withhold, in whole or in part, any information he or she is otherwise authorized to release if such official finds that the release of such information would identify a person who made a referral or submitted an application on behalf of a person for PSA, or who cooperated in a subsequent investigation and assessment conducted by a social services district to determine a person's need for such services, when such official determines that the release of such information would be detrimental to the safety or interests of the person who made the referral, submitted the application or cooperated with the subsequent investigation and assessment.

III. SAFEGUARDS

PSA and the provider of services for individuals who are diagnosed with a mental illness, mental retardation or developmental disability agree that the following safeguards will be maintained with regard to shared information relating to those receiving or being considered for services:

1. the information must be necessary to ensure the delivery of appropriate services to the individual and must be used solely for the purposes for which it was made available, such purposes to be reasonably related to the purposes and function of the inquiring agency;

2. the information will not be used for commercial or political purposes or to further the interests of the service agency where such information is not specifically being used to access or provide needed services to the individual.

3. DISCLOSURE OF INFORMATION WILL BE LIMITED TO ONLY THAT INFORMATION NECESSARY IN LIGHT OF THE REASONS FOR DISCLOSURE. ALL INFORMATION SO DISCLOSED SHALL BE KEPT CONFIDENTIAL BY THE PARTY RECEIVING THE INFORMATION. ANY STATUTORY LIMITATIONS ON DISCLOSURE IMPOSED ON THE PARTY PROVIDING THE INFORMATION SHALL APPLY TO THE PARTY RECEIVING THE INFORMATION. THE PARTY PROVIDING THE INFORMATION MUST NOTIFY THE PARTY RECEIVING THE INFORMATION OF ANY APPLICABLE STATUTORY RESTRICTIONS CONCERNING FURTHER DISCLOSURE. A NOTATION OF DISCLOSURE OF THE INFORMATION WILL BE MADE IN THE AFFECTED INDIVIDUAL'S CLINICAL OR CASE RECORD AND NOTICE OF SUCH DISCLOSURE SHALL BE GIVEN TO THE INDIVIDUAL UPON REQUEST.

IV. PROCEDURE FOR DISCLOSING SPECIFIC INFORMATION CONCERNING INDIVIDUALS

1. All requests for information between the parties to this agreement will be documented in the individual's case or clinical record. The documentation should include the specific information requested, the reason for the request, the person to whom the request was made, the person making the request, and the date of the request.

2. All responses to requests for information must be issued as soon aspossible, and in no case more than ten (10) working days after the receipt of the request unless extenuating circumstances, as agreed to by each party, necessitate a longer response time. If it is not possible to respond within ten (10) working days, the party receiving the request must issue an acknowledgment within ten (10) working days and provide a brief explanation of the reason for delay and an estimate of the additional time needed before a response will be forthcoming.

3. All disclosures of information must be documented in the individual'scase or clinical record. This notation must include a brief statement indicating the party to whom the disclosure was made, the date of the disclosure, the purpose for which the disclosure was made, and the nature of the information disclosed. Upon request, the individual must be informed of all such notated disclosures of information.

4 Pursuant to Section 473-e(3) of the Social Services Law, the commissioner or a social services official may withhold, in whole or in part, the release of any information in their possession which he or she is otherwise authorized to release, if such official finds that release of such information would identify a person who made a referral or submitted an application on behalf of a person for protective services for adults, or who cooperated in a subsequent investigation and assessment conducted by a social services district to determine a person's need for such services and the official reasonably finds that the release of such information will be detrimental to the safety or interests of such person.

V. DISCLOSURE OF OFFICE OF CHILDREN AND FAMILY SERVICES (OCFS) INFORMATION (FORMERLY DIVISION FOR YOUTH)

An agency may deny any requested information upon a determination that the release of the requested information would violate Executive Law, section 510-c which requires that the identity of any youth who is or was ever in the custody of the former Division for Youth or its successor agency, the Office of Children and Family Services (OCFS) be kept confidential, as well as their records and files.

OCFS is required to safeguard these records. Therefore, the provider will safeguard resident identities and confidential information from resident files from coming to the knowledge of or inspection or examination by any person other than one authorized to receive such information or to inspect or examine such documents.

VI. DISCLOSURE OF CONFIDENTIAL HIV/AIDS INFORMATION

Confidential HIV/AIDS information may be disclosed between authorized staff of each agency when it is necessary for the provision, supervision, monitoring or administration of health or social services to a protected individual. A "protected individual" means a person who is the subject of an HIV related test or has been diagnosed as having HIV infection, AIDS or HIV related illness. "Authorized staff" means only those employees or agents of a party to this Agreement who would, in the ordinary course of business of the agency, have access to records relating to the care of, treatment of, or provision of a health or social service to the protected individual. The term "confidential HIV/AIDS information" means any information, in the possession of a person who provides one or more health or social services or who obtains the information pursuant to a release of confidential HIV related information, concerning whether an individual has been the subject of an HIV related test, or has HIV infection, HIV related illness or AIDS, or information which identifies or reasonably could identify an individual as having one or more of such conditions, including information pertaining to such individual's contacts.

Confidential HIV/AIDS information should not be released without the consent of the protected individual or, if the individual lacks the capacity to consent, the information should not be released without the consent of the individual's authorized representative unless the release of such information is reasonably necessary for the supervision, monitoring, administration or provision of health or social services.

With regard to a written release of confidential HIV/AIDS information by a protected person or by the protected person's authorized representative, including reports on whether an individual has had an HIV related test or has been diagnosed as having AIDS, HIV infection or an HIV-related illness, such a release of information must be dated, specify to whom disclosure is authorized and the time period for which the release is effective. A general authorization for the release of medical or other information cannot be used to disclose HIV/AIDS information, unless such dual purpose is specifically indicated in the authorization. Any disclosure of confidential HIV/AIDS information also must be accompanied by the following written statement or such written statement must follow the oral disclosure within ten (10) days.

"This information has been disclosed to you from confidential records which are protected by State law. State law prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. Any unauthorized further disclosure in violation of State law may result in a fine or jail sentence or both. A general authorization for the release of medical or other information is not sufficient authorization for further disclosure."

Although the protected individual's confidential HIV/AIDS information may be shared without consent, each agency recognizes the importance of being extremely sensitive to the issues of stigma, isolation and discrimination faced by persons with HIV/AIDS in deciding to release confidential HIV/AIDS information. Each party to this Agreement shall consider the potential negative ramifications of the release of confidential HIV/AIDS information and shall weigh the perceived

harm of such disclosure against the stated need for the information before such information is released.

VII. TERMS OF AGREEMENT

1. The agencies entering into this agreement will review the terms of thisagreement at least annually.

2. Changes in the agreement may be made at any time by the mutual consentof the parties.

3. Either party may terminate this agreement by giving 30 days writtennotice to the other party.

4. It is understood by both parties that subsequent changes in law orpolicy affecting each agency may necessitate changes or modification to this model agreement. In the event that such changes or modification become necessary, this model agreement will be revised accordingly.

_____	_____
_____	_____
Title	Title
_____	_____
Agency	Agency
_____	_____
Date	Date

INFORMATIONAL LETTER

TRANSMITTAL: 92 INF-40

DIVISION: Adult Services

TO: Commissioners of Social Services

DATE: September 28, 1992

SUBJECT: Article 81 of the Mental Hygiene Law: Proceedings for Appointment of a Guardian for Personal Needs or Property Management (Chapter 698 of the Laws of 1992)

SUGGESTED DISTRIBUTION: Directors of Services
Adult Services Staff
Agency Attorneys
Staff Development Coordinators

CONTACT PERSON: Any questions concerning this release should be directed to your district's Adult Services Representative at 1-800-342-3715 as follows:

Irvin Abelman	ext. 432-2980 or (212) 804-1247
Thomas Burton,	ext. 432-2987
Kathleen Crowe	ext. 432-2996
Michael Monahan	ext. 432-2864
Janet Morrissey	ext. 432-2997

ATTACHMENTS: Article 81 of the Mental Hygiene Law (Not Available On Line)

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
88 ADM-23 83 ADM-15 91 INF-40		457	Article 9-B Articles 77, 78 & 81 of Mental Hygiene Law		

DSS-329EL (Rev. 9/89)

The purpose of this release is to inform local social services districts of a recent amendment to the Mental Hygiene Law, in relation to the appointment of guardians

for personal needs and property management for persons who are likely to suffer harm because they are unable to provide for personal needs including food, shelter, health care, or safety and/or are unable to manage property and financial affairs.

Chapter 698 of the Laws of 1992, effective April 1, 1993, repeals Article 77 and 78 of the Mental Hygiene Law which authorize the appointment of conservators and committees respectively for persons whose ability to care for their property is substantially impaired or who are judged to be incompetent. Chapter 698 replaces these two Articles with Article 81 of the Mental Hygiene Law which authorizes the appointment of a guardian whose authority is appropriate to satisfy the needs, either personal or financial, of an incapacitated person. Article 81 seeks to ensure that any appointment of a guardian is tailored and limited to only those activities for which a person needs assistance, taking into account the personal wishes, preferences and desires of the person. The standard for appointment of this new procedure focuses on the decisional capacity and functional limitations of the person for whom the appointment is sought, rather than on some underlying mental or physical condition of the person. This amendment to the Mental Hygiene Law was enacted at the request of the New York State Law Revision Commission, which had studied Articles 77 and 78 since 1987.

Article 81 attempts to ensure that an allegedly incapacitated person retains the maximum degree of independence possible and that only the least restrictive form of intervention is imposed upon the person. With the assistance of a court-appointed evaluator, a court will examine the functional level and needs of an allegedly incapacitated person and will authorize appointment of a guardian only if necessary. If a guardian is appointed, the guardian will be granted only those powers necessary to provide for the person's needs.

In addition to strong due process protections, Article 81 provides local social services districts with flexibility and creative mechanisms for the provision of necessary services to Protective Services for Adults (PSA) clients. The statute contains a number of limited and provisional remedies which will permit the courts to effectively address short-term and emergency situations in a manner which assures the provision of necessary services in the least intrusive manner while protecting the rights of the allegedly incapacitated person. These mechanisms, which are designed to provide for the personal needs and/or property management of the alleged incapacitated person, include special guardians, protective arrangements, single transactions or series of transactions, and temporary guardians. These provisions are described in greater detail in Section 81.16 of the statute.

A number of the major provisions of Article 81 are highlighted below:

1. The statute lists a number of persons who may file a petition for the appointment of a guardian, including the Department of Social Services in the county where the person alleged to be incapacitated resides (81.06).

2. The petition is usually filed in Supreme Court or County Court, although under certain circumstances the petition may be filed in Surrogate's Court (81.04, 81.05).

3. The court, at the time of issuance of an order to show cause, is required to name a court-appointed evaluator. The evaluator is given a variety of specific duties and is also given authority to protect the property of the person alleged to be incapacitated pending the hearing in the event the property is in danger of waste, misappropriation or loss (81.09).

4. The court evaluator may apply to the court for permission to inspect records of prior medical, psychological and psychiatric examinations of the person alleged to be incapacitated (81.09).

5. Counsel may be appointed for a person alleged to be incapacitated (81.10).

6. A determination that a person is incapacitated under the provisions of Article 81 must be based on clear and convincing evidence (81.12).

7. In an appropriate case, a court may, as an alternative to a long term guardian, authorize a protective arrangement, a transaction, a series of transactions, a contract, a trust or other arrangement to protect the person or property of an alleged incapacitated person. The court may also name a special guardian to assist in the accomplishment of these transactions (81.16).

8. Included in the list of who may serve as guardians are local social services officials and any community guardian programs operating pursuant to Article 9-B of the Social Service Law, provided that a community guardian program is appointed as guardian only where a special proceeding for the appointment of a guardian under this statute has been commenced by a social services official with whom the program was contracted (81.19).

9. If the court determines that a guardian is necessary, the court is required to delineate the specific powers of the guardian which constitute the least restrictive form of intervention consistent with the person's functional limitations and the likelihood of harm. The incapacitated person retains all other powers and rights except those specifically granted to the guardian (81.15, 81.29).

10. A more extensive statement of the powers and duties than exists in current law is set forth in Sections 81.20 (Duties of Guardian), 81.21 (Powers of Guardian; Property Management) and 81.22 (Powers of Guardian; Personal Needs).

11. The statute allows for the appointment of a temporary guardian, upon showing of danger in the reasonably foreseeable future to the health and well being of the alleged incapacitated person, or danger of waste, misappropriation, or loss of the property of the alleged incapacitated person. The court may also issue a temporary restraining order to enjoin the sale, disposition, assignment, transfer or dissipation of property (81.23).

12. The guardian or temporary guardian may be required to file a bond prior to appointment. A community guardian program may file a consolidated bond of up to $1.5 million dollars (81.25).

13. The statute provides for the court to establish a plan for the reasonable compensation of the guardian (81.28).

14. Detailed reporting requirements are included for court-appointed evaluators and guardians (81.09, 81.30, 81.31, 81.32, 81.33).

15. Article 81 includes provisions for the removal of guardians (81.35), the discharge or modification of the powers of guardians (81.36), resignation or suspension of the powers of guardians (81.37) and vacancy in office (81.38).

16. Guardians are required to complete a training program which includes the legal duties and responsibilities of the guardian, the rights of the incapacitated person, the available resources to aid the incapacitated person, an orientation to medical terminology, and the preparation of annual reports, including financial accounting.

17. Court-appointed evaluators are also required to complete a training program which includes the legal duties and responsibilities of the evaluator, the right of the incapacitated person with emphasis on due process rights, the available resources to aid the incapacitated person, an orientation to medical terminology, entitlements, and psychological and social concerns relating to the disabled and frail older adults.

18. Any conservators or committees appointed under Articles 77 and 78 of the Mental Hygiene Law shall continue in force and effect until modified or abrogated by a judge pursuant to Article 81.

Local social services districts currently are required to petition for the appointment of a conservator or committee and/or serve as conservator or committee in appropriate situations where no one else is willing and able to act on behalf of the client in accordance with Section 473.1(c) and (e) of Social Services Law and Section 457.1(c)(7) of the Department's regulations. As of April 1, 1993, they will be required to petition for the appointment of a guardian and/or serve as a guardian, special guardian or temporary guardian when necessary. Therefore, Protective Services for Adults (PSA) and legal staff should familiarize themselves with the provisions of Article 81.

The Department will be revising its training programs to reflect the provisions of Article 81, particularly the Legal Aspects of PSA training initiative which PSA caseworkers and supervisors are required to attend. In addition, the Department's Division of Legal Affairs will be conducting training for local social services district attorneys in conjunction with the New York Public Welfare Association. Additional implementation activities may be forthcoming based upon any needs which are identified by the districts.

A copy of Article 81 is attached to this release.

William E. Gould
Acting Deputy Commissioner
Division of Adult Services

Eliot Spitzer
Governor

NEW YORK STATE
OFFICE OF CHILDREN & FAMILY SERVICES
52 WASHINGTON STREET
RENSSELAER, NY 12144

Gladys Carrión, Esq.
Commissioner

Administrative Directive

Transmittal:	07-OCFS-ADM-04
To:	Commissioners of Social Services
Issuing Division/Office:	Division of Development and Prevention Services Office of Program Support Bureau of Adult Services
Date:	March 26, 2007
Subject:	Protective Services for Adults (PSA): Memorandum of Understanding with Office of Mental Retardation and Developmental Disabilities (OMRDD)
Suggested Distribution:	Directors of Services Adult Services Staff Agency Attorneys Staff Development Coordinators
Contact Person(s):	Bureau of Adult Services Director Susan B. Somers Susan.Somers@ocfs.state.ny.us Your district's Bureau of Adult Services program representative: Michael Cahill Michael.Cahill@ocfs.state.ny.us Deborah Greenfield Deborah.Greenfield@ocfs.state.ny.us Richard Piche Rich.Piche@ocfs.state.ny.us Deborah Schwencke Deborah.Schwencke@ocfs.state.ny.us Paula Vielkind Paula.Vielkind@ocfs.state.ny.us
Attachments:	OCFS-PSA/OMRDD-DDSO Memorandum of Understanding
Attachment Available Online:	No

Previous ADMs/ INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
93 INF-37	93 INF-37	457	473 SSL 16.19 MHL		

I. Purpose

The purpose of this Administrative Directive is to inform Local Departments of Social Services (LDSS) of the enactment of Chapter 536 of the Laws of 2005, as amended by Chapter 356 of the Laws of 2006. This new law requires the Commissioner of OMRDD to investigate reports of physical, sexual or emotional abuse, or active, passive or self-neglect, of any adult living in the community presumed to be diagnosed with mental retardation or a developmental disability known by the OMRDD Commissioner or any of OMRDD's duly authorized service providers. Further, it directed OMRDD and OCFS to develop the attached Memorandum of Understanding (MOU) delineating the responsibilities of both agencies regarding the reporting and investigating of suspected cases of abuse of adults diagnosed with mental retardation and/or a developmental disability. This MOU shall be executed by each Developmental Disabilities Services Office (DDSO) and each LDSS within its jurisdiction and reviewed at least annually.

II. Background

In 1992, a report was issued by the Commission on Quality of Care for the Mentally Disabled which strongly recommended that the NYS Department of Social Services (now OCFS) and OMRDD clarify the responsibilities of Protective Services for Adults (PSA) and other agencies serving adults diagnosed with mental retardation and/or a developmental disability when allegations of abuse, neglect or exploitation were conveyed regarding incidents in the community (as opposed to a protected, residential setting). The former DSS in conjunction with OMRDD developed a model Memorandum of Understanding (MOU) for use by PSAs and DDSOs. Use of the model MOU was recommended but not required. With the enactment of Chapter 536 of the Laws of 2005, PSAs and DDSOs are now required to execute an MOU.

III. Program Implications

This MOU covers the following topics:

- the eligibility criteria for PSA and OMRDD services;
- the referral process between each agency;
- service delivery;
- procedures for investigating abuse, neglect or exploitation;

- referrals to law enforcement;
- dealing with high-risk cases; • information sharing; and
- conflict resolution.

The MOU will support Section 473 of Social Services Law, which requires that LDSSs plan with other public, private and voluntary agencies for the purpose of assuring maximum local understanding, coordination and cooperative action in

the provision of appropriate services to PSA clients. Copies of the MOU are also being sent to the DDSOs by OMRDD, since OMRDD is responsible to provide services to any adult living in the community thought to be diagnosed with mental retardation or a developmental disability who is known by the OMRDD Commissioner or any of OMRDD's duly authorized service providers.

IV. Required Action

Each LDSS Protective Services for Adults (PSA) unit must:

- execute a Memorandum of Understanding (MOU) with the DDSO that provides services to clients in that county;
- submit a copy of the fully executed MOU to the NYS OCFS Bureau of Adult Services, 52 Washington Street, Rensselaer, NY 12144 as soon as the agreement is reached and whenever it is modified;
- compile, either by use of the Adult Services Automated case management Program (ASAP) where available, or manually, a log of the clients referred to PSA by OMRDD or any of its duly authorized service providers together with case details on service plans and outcomes sufficient for OCFS to develop a systemic issues report summarizing strategies and successes. LDSS shall submit the log to the Bureau of Adult Services by December 30 of each calendar year.
- The OCFS Bureau of Adult Services, in concert with OMRDD, is required to submit a report addressing referrals regarding adults diagnosed with mental retardation or a developmental disability and service delivery to the Governor, Temporary President of the Senate and Speaker of the Assembly in early January of the following year.

V. Systems Implications

None at this time.

VI. Effective Date: Immediately

s/s Jane G. Lynch

_____

Issued By:
Name: Jane Lynch
Title: Deputy Commissioner
Division/Office: Division of Development and Prevention Services
Office of Program Support
Bureau of Adult Services

3

OMRDD-DDSO / OCFS-PSA MEMORANDUM OF UNDERSTANDING

I. PURPOSE

This agreement is between _____ Developmental Disabilities Services Office (DDSO) and the _____ County/Local Department of Social Services (LDSS). The agreement sets forth the joint responsibilities of the DDSO and the LDSS pertaining to the abuse reporting for individuals with mental retardation or developmental disabilities. The DDSO provides services to such persons as defined in Section 1.03(22) of the Mental Hygiene Law (MHL). The LDSS through its Protective Services for Adults program (PSA) provides protective services to impaired individuals over 18 years of age as defined in Article 9-B of the Social Services Law (SSL). Pursuant to Chapter 536 of the Laws of 2005, which amended Section 16.19 MHL, each DDSO and LDSS must enter into a Memorandum of Understanding (MOU) to ensure the appropriate reporting and investigation of suspected cases of abuse of adults with mental retardation or developmental disabilities.

Both entities recognize that each has a unique role in service provision to adults with mental retardation or developmental disabilities. Both entities also recognize that the needs and interests of said adults will be better served with a clear delineation of the roles and responsibilities of each entity with regard to such adults who are subjected to abuse, neglect or exploitation. Both the DDSO and the LDSS/PSA enter into this agreement in a spirit of interagency collaboration to facilitate the coordination of appropriate and necessary services to adults with mental retardation or developmental disabilities.

II. PSA ELIGIBILITY CRITERIA AND SERVICES

All adults 18 years of age or older who meet all of the following three criteria are eligible for intervention:

1. are incapable of meeting their own basic needs or protecting themselves from harm due to mental and/or physical incapacity; and

2. are in need of protection from actual or threatened harm, neglect or hazardous conditions caused by the action or inaction of either themselves or other individuals; and

3. have no one else available who is willing and able to assist them responsibly.

Services available under PSA include counseling, locating social services, medical care and other resources in the community, advocacy, homemaker, housekeeper/chore services, money management, assistance in finding alternative living arrangements, and pursuing appropriate actions on behalf of adults with mental retardation or developmental disabilities who require involuntary intervention. These actions may include pursuing court orders to: (1) obtain access to the person in accordance with SSL 473-c; (2) provide short-term involuntary protective services in accordance with SSL 473-a; (3) request the appointment of a guardian; (4) obtain an Order of Protection under Article 8, Family Court Act.

III. OFFICE OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES (OMRDD) ELIGIBILITY CRITERIA AND SERVICES

OMRDD provides services to persons with diagnoses of developmental disabilities. Developmental disability is defined in Article 1, Section 1.03(22) of the Mental Hygiene Law as a disability of a person which:

1. is attributable to mental retardation, cerebral palsy, epilepsy, neurological impairment, familial dysautonomia or autism;

2. is attributable to any other condition of a person found to be closely related to mental retardation because such condition results in similar impairment of general intellectual functioning or adaptive behavior to that of persons with mental retardation or requires treatment and services similar to those required for such persons; or

3. is attributable to dyslexia resulting from a disability described in subparagraph (1) or (2) of this paragraph; and

4. originates before such person attains age twenty-two; and

5. has continued or can be expected to continue indefinitely; and

6. constitutes a substantial handicap to such person's ability to function normally in society.

Services provided by OMRDD directly or via an authorized or certified OMRDD voluntary provider include various day and residential services, service coordination and clinical services.

IV. REFERRAL PROCESS

A. DDSO to LDSS/PSA

When a report of suspected abuse of an adult who may have mental retardation or developmental disabilities is made to the DDSO, the DDSO shall determine by whatever means it may have available, if OMRDD or one of its voluntary providers has, as of January 1, 2005 or later: (1) provided residential or day program services to the person; or (2) if the person has received medicaid service coordination or home and community based waiver services. If the DDSO cannot reasonably determine that such person has received services from OMRDD or one of its duly authorized providers then the DDSO shall immediately, or as soon as practicable, make a referral to LDSS/PSA of the suspected adult abuse case.

If the DDSO finds that either (1) or (2) above are met, then the DDSO or the voluntary provider shall investigate the reported case pursuant to OMRDD regulations at 14 NYCRR Part 624. If the DDSO or the voluntary provider, after making reasonable efforts, cannot gain access to the adult to investigate and/or finds that the adult needs protective services that the DDSO or voluntary provider cannot provide, then the DDSO or the voluntary provider shall make a referral to the LDSS/PSA unit responsible for Intake. The DDSO or voluntary provider will clearly state the reasons for the referral and outline the risks to the adult in his/her situation. The phone referral will be followedup by the DDSO or voluntary provider giving LDSS/PSA any available relevant written or oral information that the DDSO or its voluntary providers may have regarding the individual's developmental and psychosocial history. The DDSO or the voluntary provider shall assist in the preparation of the affidavit establishing the factual basis for pursuing any necessary order by providing all relevant and available documentation in support that it may have as required by the County Attorney. The County Attorney that represents the LDSS/PSA shall determine if there are sufficient grounds to proceed with the order. If granted, the DDSO or the voluntary provider shall accompany LDSS/PSA upon execution of the order. The DDSO must forward reports of the suspected adult abuse case to the Commission on Quality of Care and Advocacy for Persons with Disabilities within 48 hours of receipt and indicate if such report was referred to LDSS/PSA.

Upon receipt of a PSA referral from the DDSO, the LDSS/PSA will determine whether to accept or reject the case for a PSA assessment or request additional information as needed. If additional information is needed which is pertinent to the person's potential eligibility for PSA, the LDSS/PSA will request information from appropriate sources to enable a decision to be made as to whether the case will be accepted for a PSA assessment. In any case, a decision will be made whether to accept the case for assessment within 24 hours after the referral is received. If, on the basis of information supplied by the DDSO or voluntary provider and any additional information obtained by the LDSS/PSA, it appears that the person may be eligible for PSA, the case must be accepted for assessment.

A case will be rejected for assessment only if PSA eligibility can be conclusively ruled out. If any doubt remains about a person's PSA eligibility, the case will be accepted for assessment. LDSS/PSA will notify the DDSO or the voluntary provider of its decision to accept or reject a case immediately.

Upon acceptance of a referral for PSA assessment, the assigned LDSS/PSA caseworker will visit the referred individual within three working days of the referral (or 24 hours if the situation is life threatening) in accordance with the regulations set forth at 18 NYCRR Section 457.1 (c) (2). Either agency will perform joint visits when requested by the other agency.

B. LDSS/PSA ASSESSMENT PROCESS

During the 60 day period between the acceptance of a referral and the determination of PSA eligibility, LDSS/PSA will assess the person's needs and provide or arrange for services, as indicated in 18 NYCRR Section 457.1 (c) to meet the consumer's needs which have been identified in the assessment/investigation process.

As soon as reasonably possible, but no later than 60 calendar days after the referral date, a determination will be made whether the case will be opened for PSA beyond the assessment period. Cases which do not meet the "PSA Client Characteristics" will not be opened for ongoing PSA services (i.e. cases in which the identified risk factors have been resolved during the 60 day assessment process or cases in which there is no indication of abuse, neglect or exploitation, or the adult has a responsible person(s) or entity(ies) willing and able to meet their needs). Upon making such a decision LDSS/PSA will inform the DDSO within 7 days. For those cases which will be opened for PSA beyond the 60 day assessment period, the DDSO and LDSS/PSA will work collaboratively, as necessary, on a written case plan which outlines service goals, services to be rendered, the role of each agency and a schedule of treatment conferences including frequency, site and participants. The written case plan will be made part of the case record of each agency.

C. PSA TO DDSO

Based upon information obtained at referral or any subsequent investigation of a suspected adult abuse case conducted by LDSS/PSA, it will refer adults with mental retardation or developmental disabilities who may need services to the appropriate DDSO. However, a referral by LDSS/PSA to a DDSO does not negate LDSS/PSA's responsibilities on behalf of persons who are eligible for PSA as specified in this agreement and in 18 NYCRR Section 457.1 (b). For those cases which require PSA involvement beyond the 60 day assessment period, within two weeks of receipt of a referral from LDSS/PSA, the DDSO and LDSS/PSA will participate in joint case management visit by both agencies with the client. The visit will be arranged and coordinated by LDSS/PSA in cooperation with the DDSO. The DDSO will, within 7 days of the joint visit or as soon as possible thereafter, advise LDSS/PSA as to whether or not the adult referred is eligible for OMRDD services, whether or not the DDSO can provide or arrange for services to the individual, and the nature of such services to be provided.

For persons with mental retardation or developmental disabilities who are not eligible for PSA services, the DDSO will assume responsibility for providing or arranging for the provision of necessary services to these individuals. Upon receipt of a referral from LDSS/PSA, the DDSO will assess the nature and extent of the person's disabilities, their need for services, and, if found eligible by the DDSO, will plan for services that are appropriate and available.

In cases of dually diagnosed individuals (developmental disability and mental illness) in which there is uncertainty about which service system (OMRDD or OMH) has primary responsibility, OMRDD will work with the Office of Mental Health to ascertain the primary diagnosis of the adult. OMRDD will notify LDSS/PSA as to which agency (OMRDD or OMH) is assuming primary responsibility for the case.

Within 30 days of acceptance of a case by the DDSO in which LDSS/PSA will be involved beyond the 60 day assessment period, both agencies will jointly develop a written case plan which will outline service goals, services to be rendered, the specific service provider, the anticipated date services will begin, and the roles of each agency, including which agency will act as primary case manager. The primary case manager will be determined on a case by case basis, depending on the needs of the person. To the extent possible, the joint case plan shall be consistent with the PSA service plan which must be completed within 60 days of the PSA referral date in accordance with 18 NYCRR Section 457.2(b)(4). The written plan must be made part of the individual's record at each agency.

D. SERVICE DELIVERY

In mutually served cases where both LDSS/PSA and OMRDD are involved, each agency will take responsibility for those activities assigned to them in the written case plan.

When a need is identified for placement specifically within the OMRDD system, particularly emergency placement of a person with mental retardation or developmental disabilities, the DDSO will be responsible for seeking a placement within their system.

Each agency will notify the other of significant changes in the shared case's condition or situation (e.g., changes in medical status, living situation, loss of benefits) as soon as practicable after a change is identified.

Any activity or decision by either agency which would have the effect of discontinuing services or otherwise significantly changing the service plan must be communicated in writing to the other agency at least 30 days prior to the changes or as soon as practicable if 30 days' notification is not possible. Verbal communication may appropriately preface the written communication.

Each agency may at any point call a case conference involving both agencies and other service providers if it is felt that a conference is needed to review significant changes in the person's situation or to devise an appropriate service plan.

V. PROCEDURES FOR INVESTIGATING ABUSE, NEGLECT OR EXPLOITATION

A. PERSONS WHO THE DDSO REASONABLY BELIEVES HAVE MENTAL RETARDATION OR DEVELOPMENTAL DISABILITIES AND WHO HAVE RECEIVED SERVICES FROM OMRDD CERTIFIED, AUTHORIZED OR FUNDED PROGRAMS

The investigation of alleged abuse or neglect of consumers while under the auspices of an OMRDD certified, authorized or funded program is the responsibility of the agency staff (the DDSO is the "agency" for state-operated programs). Requirements concerning the review and reporting of incidents of alleged abuse or neglect by OMRDD certified or authorized programs are stated in OMRDD regulations at 14 NYCRR Part 624. Agencies are also required to take such action as is necessary to protect the safety and welfare of the consumer and develop recommendations for protective/corrective actions of the alleged abuse or neglect.

The agency is also responsible for intervening when abuse or neglect is suspected when the consumer is not under the auspices of the agency (e.g., at home) or involves people who are not affiliated with the agency. The agency may also make a referral to LDSS/PSA when the remedies of the agency are insufficient. The agency may request a joint visit with LDSS/PSA staff or other specific PSA involvement, such as assistance in obtaining a court order to access the person. LDSS/PSA will accept the referral in accordance with its standard procedures and will collaborate with the agency as needed.

B. PERSONS WHO THE DDSO REASONABLY BELIEVES DO NOT HAVE MENTAL RETARDATION OR DEVELOPMENTAL DISABILITIES

In the event that a report is made to the DDSO or to one of its voluntary providers alleging abuse, neglect or exploitation concerning such a person, the DDSO or the voluntary provider shall make a referral to LDSS/PSA. The DDSO or the voluntary provider shall provide any relevant information it may have available regarding the person's developmental and psychosocial history to LDSS/PSA. LDSS/PSA will accept the referral in accordance with its standard procedures, and will assume initial responsibility for the investigation of such reports and intervention in the situation.

If during the investigation of the referral, LDSS/PSA becomes aware that the person may have a developmental disability and that resolution of the abuse may be facilitated by the provision of services through OMRDD, LDSS/PSA may make a referral to the DDSO for an eligibility determination and assessment for potential services. The DDSO will utilize its standard intake procedures upon receiving the referral. Either agency will perform joint visits when requested by the other agency.

C. HIGH RISK CASES

The following protocol will be followed by the DDSO and LDSS/PSA in cases identified by either agency to be a high risk situation (imminent risk to the person’s health, safety or stability of living arrangement).

<u>Existing Cases Being Mutually Served by LDSS/PSA/DDSO</u>

In cases already being mutually served by both agencies, the agency which first identifies the high risk situation will immediately notify the other agency. The purpose of the notification will be to arrive at an immediate plan to address the crisis situation using the resources available to both agencies. If joint consultation is not possible, the agency which identified the high risk situation must take action to resolve the crisis and notify the other agency after the fact.

The primary focus in high risk cases is the resolution of the crisis. When determined feasible, LDSS/PSA and the DDSO will make every effort to arrange a joint home visit as soon as possible to assess the crisis situation (within 24 hours if the situation is life threatening) but no later than three (3) working days following the identification of the situation.

If determined necessary, either agency may call an immediate case conference to devise a plan to address the crisis situation. The plan will come from the meeting and will specify services to be provided and the role of each agency.

New Cases

In new cases, the supervisor of the agency which identifies the high risk situation will notify, when possible, the supervisor of the other agency by telephone if it is felt that the assistance of the other agency is necessary and appropriate to address the situation. The referring agency will clearly explain the high risk factors in the person's situation and the need for priority attention. When determined feasible, LDSS/PSA and the DDSO will make every effort to arrange a joint home visit as soon as possible to assess and resolve the crisis situation (within 24 hours if the situation is life threatening) but no later than three (3) working days following the identification of the situation.

D. NOTIFICATION TO LAW ENFORCEMENT

In cases of alleged abuse, neglect or exploitation in which it is suspected that a crime has been committed, both parties recognize that law enforcement must be involved and will cooperate in this process. OMRDD regulations at 14 NYCRR Sec. 624.6 (d) require that in the case of any reportable incident or allegation of consumer abuse where a crime may have been committed, it is the responsibility of the program administrator or designee of an OMRDD operated or certified program to notify law enforcement officials. For abuse occurring in the community in which it is suspected that a crime has been committed, a referral must be made to law enforcement. Additionally, the LDSS/PSA is mandated to report to law enforcement pursuant to Section 473-5 SSL when they have reason to believe a criminal offense has been committed against a client. Such notification may be made by the individual, LDSS/PSA or OMRDD/program staff, preferably through consultation of all three parties and it shall be documented in the individual's case record at each agency.

VI. INFORMATION SHARING

Both agencies agree to share that information concerning the referred or mutually served person which is necessary to develop and implement service plans, to the extent permitted by applicable laws and regulations including Title 18 NYCRR Part 357 and Section 33.13 MHL. Information may be disclosed where such disclosure is reasonably necessary to assess an individual or to provide protective services to an individual. Pursuant to Chapter 536 of the Laws of 2005, the DDSO shall be deemed a provider of services for the purposes of access to adult protective records under Section 473-e SSL.

Both agencies agree to orient their staffs concerning the implementation of this agreement. Both agencies agree to participate in training of each other's staff regarding the mission and operation of each program.

VII. CONFLICT RESOLUTION

The DDSO and LDSS/PSA each retain responsibility for making eligibility decisions regarding their own programs and/or services and determining the type, duration and scope of services they will provide to eligible persons. However, in order to promote coordination and collaboration, each entity shall seek to resolve any conflicts in accordance with the process described below.

In cases of disagreement between the DDSO or its voluntary providers and LDSS/PSA staff about a person's eligibility for services or the appropriateness of a services plan, every effort shall be made to resolve the conflict at the staff/practitioner level. If resolution cannot be achieved at that level, supervisory staff in each agency will confer to reach an acceptable resolution. If a dispute cannot be resolved at the supervisory level, the dispute will be referred to the administrative level at each agency (i.e., the DDSO Director or his/her designee and the Commissioner of the Local Dept. of Social Services or his/her designee) for resolution. Both parties agree to make every effort to resolve disputes through the internal conflict resolution process discussed above. If a dispute cannot be resolved by the two parties, each party reserves the right to pursue an equitable resolution of the matter, including requesting guidance from OCFS or OMRDD administrative staff.

VIII. TERMS OF AGREEMENT

OMRDD and OCFS will review the terms of this agreement at least annually. Changes to the agreement may be made at any time by mutual consent.

Nothing in this agreement shall substitute, or represent a change in, either agency's legally mandated responsibilities.

_____ _____

COMMISSIONER_____ County DATE
Department of Social Services

_____ _____

DIRECTOR OF _____ DATE
DDSO

1/24/07

Andrew M. Cuomo *Governor*
Commissioner

52 WASHINGTON STREET **Sheila J. Poole**
RENSSELAER, NY 12144

Administrative Directive

Transmittal:	21-OCFS-ADM-03
To:	Commissioners of Social Services
Issuing Division/Office:	Child Welfare and Community Services Bureau of Adult Protective Services
Date:	February 18, 2021
Subject:	**Changes in Annual Assessment Requirements for Community Guardianship Programs**
Suggested Distribution:	Directors of Social Services Adult Protective Services Supervisors Community Guardianship Program Providers
Contact Person(s):	Shelly.Fiebich-Aubertine@ocfs.ny.gov Susan.Hollander@ocfs.ny.gov
Attachments:	None

Previous ADMs/INFs	Releases Cancelled	NYS Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
		18 NYCRR 457.12(d)	Chapter 579 of the Laws of 2019; Social Services Law §473-d; Mental Hygiene Law § 81.31		

I. Purpose

The purpose of this Administrative Directive (ADM) is to inform local departments of social services (LDSSs) of Chapter 579 of the Laws of 2019, which amends Social Services Law (SSL) § 473-d by eliminating redundant and unnecessary reporting requirements and reduces the number of required annual assessments for clients of a community guardianship program.

II. Background

The community guardianship program provides for the appointment of either an LDSS, or a nonprofit under contract with an LDSS, to act as the legal guardian for an incapacitated adult served by Adult Protective Services (APS) when no other person or entity is available to act as a guardian for such adult. Previously, SSL § 473-d required community guardianship programs to obtain annual assessments from two qualified psychiatrists (or one qualified psychiatrist and one qualified psychologist) independent of the community guardianship program. These psychiatric and/or psychological assessments were then provided to the appointing court to determine whether the person receiving guardianship services continued to need a guardian.

Additionally, since 2004, Mental Hygiene Law (MHL) § 81.31 requires every guardian to file an annual report every May. This annual report must include a statement prepared by a physician, psychologist, nurse, clinician, social worker, or other person evaluating the condition and functional level of the person for whom the community guardianship program serves as guardian. The statement must be prepared within the three-months prior to the filing of the report.

The amendment to SSL § 473-d eliminates the previously required assessments by two mental health professionals each year and now requires a single evaluation annually by a physician, psychologist, nurse, clinician, social worker or other person evaluating the conditioning and functioning of the person for whom the community guardianship program serves regarding whether guardianship continues to be appropriate. The evaluation cannot be conducted by a professional affiliated with a community guardianship program, and the evaluating professional must act within their lawful scope of practice as established under the education law. The amendment to SSL § 473-d aligns requirements with existing reporting requirements in MHL § 81.31.

III. Program Implications

In addition to reducing the number of required annual assessments, the revision provides greater flexibility regarding who may provide an annual evaluation of the person under guardianship. This amendment may reduce costs incurred by the LDSS for contracting out for these duplicative assessments. As with the prior requirements, the appointing court must still be informed of the results of such evaluation or examination, and as a result of the evaluation, the court may modify or discharge the guardian pursuant to MHL § 81.31.

IV. Required Action

LDSSs and community guardianship programs are advised to broaden the scope of professionals leveraged to examine and assess the necessity of continuing a person's guardianship. The changes in these requirements will allow greater flexibility in that endeavor.

V. Systems Implications

None.

VI. Effective Date

This ADM is effective immediately.

/s/ Lisa Ghartey Ogundimu
Issued by:
Name: Lisa Ghartey Ogundimu
Title: Deputy Commissioner
Division/Office: Child Welfare and Community Services

Seeking Orders to Gain Access to Adults Believed to be in Need of Adult Protective Services: Best Practice Guidelines

I. Purpose

The purpose of this document is to provide best practice guidelines as well as a summary of the applicable law and OCFS policy guidance to assist local district Adult Protective Services (APS) staff and attorneys representing APS staff and local commissioners of social services when dealing with this topic. (Footnote: although statute and regulations use both "PSA" and "APS" interchangeably, in this document we will use the term "APS" unless we are citing a source that uses "PSA.")

II. Introduction

Social Services Law section 473-c authorizes a social services official to apply to the court for an order to gain access to a person to assess whether such person is in need of adult protective services. The social services official may apply when:

- The official has reasonable cause to believe such person may be in need of adult protective services; and
- The official is refused access by such person or another individual.

The law also contains provisions which:

- Require that a social services official who is refused access must assess, in consultation with a supervisor, whether or not it is appropriate to apply for an order to gain access to such person. Such assessment must be made as soon as necessary under the circumstances, but no later than 24 hours after the investigating official is denied access. The determination of whether or not to apply for an order to gain access and the reasons therefor shall be documented in the investigation file.
- Set forth the information that needs to be included in an application for an order to gain access.
- State the determination to be made by the court in order to grant the application for access.
- State how an order for access, if granted, is to be carried out.

III. Seeking Orders to Gain Access

A. Seeking Voluntary Access

Best Practice for APS workers is to use engagement and persuasive skills to seek voluntary agreement by the person who may be in need of APS or another person who may be controlling access. Explain that you are from APS, that you have received information about a concern for their safety or welfare, and that you are there for the purposes of talking with them and seeing whether they are ok.

As stated in the OCFS Adult Services Practice Model, "All adults have the right to be safe and to live with dignity and with self-determination to the extent possible." With respect to

Engagement: “Since most vulnerable adults have the capacity to refuse offered services, best practice is for Adult Services worker to carefully and gently engage the client to make a connection and to offer services.”

As stated in the National Adult Protective Services Association (NAPSA) APS Recommended Minimum Program Standards: “Adults retain all their civil and constitutional rights, i.e. the right to live their lives as they wish, manage their own finances, enter into contracts, marry, etc. unless a court rules otherwise.” Also: “Use the least restrictive services first.”

B. What if no one is home when APS attempts a home visit? Is that a “Refusal?”

No. A petition for an order to gain access is based on an actual refusal of access, either by the person who may be in need of APS, or by somebody else. It does not apply to a situation where no one was home, or no one was answering the doorbell or a knock at the door, and there is no reason to believe that anyone was at home when APS came by to conduct an investigation or assessment.

C. Access to What? Is it Access to the *Person* or to the *Person in their Home ?*

We have heard that there is sometimes confusion as to whether there is a basis for APS to seek an access order in the case where APS has spoken to the person outside of their home, but the person or someone else has denied access to the home. This confusion may be due to the fact that the statute refers to “an order to gain access to a person.” Social Services Law (SSL) section 473-c 1. However, the statutory language goes on to say:

> A social services official may apply to the supreme court or county court for an order to gain access to a person *to assess whether such person is in need of protective services for adults in accordance with the provisions of section four hundred seventy-three of this article* when such official, having reasonable cause to believe that such person may be in need of protective services, is refused access by such person or another individual.

The statute further states that an application for an order to gain access shall include, among other things:

> (g) that the social services official seeks an order solely for the purposes of *assessing the need of a person for protective services for adults in accordance with the provisions of section four hundred seventy- three of this article and applicable regulations of the department.*

If the court grants the application, the court shall issue an order:

> authorizing the social services official and other such officials as may be designated by such official, accompanied by a police officer*, to enter the premises to conduct an assessment* to determine whether the person named in the application is in need of protective services for adults.

SSL section 473-c (4).

The law is clear that when an order to gain access is sought, the purpose of the access is to conduct an assessment of the person in accordance with applicable regulations.
APS regulations require "assessing the individual's situation and service needs." 18 NYCRR section 457.1(d)(3). Regulations further state that for every type of APS assessment that is conducted:

The case record of each PSA client shall include a PSA assessment/services plan consisting of the following information:

(iii) household composition;

(iv) residence and living arrangements;

(v) income and resources;

(vi) medical and mental limitations

(vii) identification of significant other persons such as family members and friends and their willingness and capability to assist the individual 18 NYCRR section 457.2(b)(1).

These and other components of the APS assessment cannot adequately be explored without access to the individual in their home to see how the individual is living in his/her home environment and to have access to records and persons found in the home. **Even if APS staff has access to the person outside of their home for an initial interview, if there is reason to believe the person may be in need of APS and that therefore an assessment must be conducted, access to the home is necessary in order to conduct a full assessment of the needs of the client.**

If the referral cites hazardous environmental conditions in the home, lack of adequate food, medicine, furnishings, utilities, or if there is any allegation of abuse, neglect or financial exploitation, these factors make it even more critical that APS have access to the home in order to conduct a proper assessment of the risks and needs of the client.

The law is also clear that when an access order is issued, it includes access to the premises, i.e. to the home, for the purposes of conducting an assessment of the person in their home, in accordance with applicable regulations.

D. Upon Refusal of Access

If the person who may be in need of APS, or another person, refuses access to APS, what are the next steps?

(a) Regulatory requirements:

If an employee of a social services district who is authorized to provide PSA is denied access to a person who is believed to be in need of PSA by another individual or by such person, the social services district must take the following action:

(1) Enlist the aid of family members, friends, neighbors, or staff of other appropriate agencies, including law enforcement agencies, for the purposes of persuading the individual(s) responsible for denying access to a person who may be in need of PSA to permit the district to complete an assessment of the person's need for PSA; and

(2) If the efforts initiated in accordance with paragraph (1) of this subdivision are unsuccessful, the social services district must determine whether or not to apply to the Supreme Court or the County Court for an order to gain access to a person who may be in need of PSA, in accordance with the provisions of this section. In deciding whether or not to apply for such an order, the social services district must determine if the information provided by the referral source and other persons familiar with the situation and the observations of staff of the social services district warrant such action. 18 NYCRR section 457.11 (b) (1)(2)

(b) Social Services Law.

As noted above, the SSL requires that a social services official who is refused access must assess, in consultation with a supervisor, whether or not it is appropriate to apply for an order to gain access to such person. Such assessment must be made as soon as necessary under the circumstances, but no later than 24 hours after the investigating official is denied access. The determination of whether or not to apply for an order to gain access and the reasons therefor must be documented in the investigation file. SSL section 473-c, (1)

Please note that this provision does not create a requirement that the local district petition for access within a certain time frame, or at all. It merely requires that once there has been a refusal of access, the APS worker consult with a supervisor to assess whether or not it is appropriate to petition <u>at that point</u> for an access order, and document the reasons for the determination to apply or not apply at that point.

(c) Policy Directives provide additional guidance.

- Administrative directive <u>87 ADM 6 (</u>Orders to Gain Access). This ADM states that the APS caseworker needs to report to the supervisor when access is denied, and the caseworker and the supervisor need to discuss appropriate casework steps to take, consistent with regulations, to try to seek access. If additional efforts to obtain access are unsuccessful and if the APS caseworker continues to believe the person may be in need of APS, certain specified information must be presented to the supervisor and documented in the case record. (See section E. below regarding the specific information that must be included in the application for an order to gain access.)

This ADM provides guidance on the next steps: If the supervisor concurs with the need for a court order to gain access, the information shall be promptly presented to the county or agency attorney. However, if the supervisor is not satisfied that sufficient

efforts have been made to obtain access voluntarily, the supervisor must advise the caseworker of the additional efforts which must be made.

The ADM states that the supervisor's decision whether or not to support the need for an order to gain access, the reasons for the determination and the information obtained by the caseworker shall be recorded in the case record. If APS casework or supervisory staff need guidance about the legal sufficiency of their case for presentation to the court, they should promptly arrange to consult with the county or agency attorney.

- Administrative Directive 93 ADM 23 (APS Intake). This ADM includes the following important language:

If an adult for whom a PSA referral is received cannot be located or if the caseworker is denied access to the adult's home, prompt and continuous follow up efforts must be made to locate and to obtain access to the adult in the adult's home. Follow up efforts must include contacts with any other persons who might be of assistance in locating and/or obtaining access to the adult, including the referral source, staff of other agencies, family members, friends, neighbors, and landlord or building superintendent. Efforts to locate and/or obtain access to the adult must continue as long as there is a reason to believe that the adult may need PSA. If reasonable efforts have been made to obtain access to an adult, and access continues to be denied, steps must be taken to pursue an access order. The number and frequency of follow-up home visits must be commensurate with the severity of the case situation, as indicated by the information obtained during the intake process.

- Administrative Directive 12-OCFS-ADM-05 (Protective Services for Adults: Chapter 412 of the Laws of 2011). This ADM advises districts of the steps that must be taken to implement the provisions of Chapter 412 of the Laws of 2011, which contains the provisions of the SSL set forth in section D(b) above. The ADM states that while Chapter 412 of the Laws of 2011 does not specify the form of the supervisory consultation that must occur after a refusal of access occurs, acceptable forms of consultation are in person or by telephone, so long as there is a sufficient opportunity to discuss the pertinent details of the case. Such consultation should not occur by email only. The ADM also states that since the law requires consultation with a supervisor within 24 hours of the refusal of access, the district will need to arrange to have necessary APS caseworkers, supervisors and, as needed, counsel available to make such determinations within the prescribed timeframe.

E. Required information for Application for Order to Gain Access

SSL section 473-c provides that such application shall state, insofar as the facts can be ascertained with reasonable diligence:

a. The name and address of the person who may be in need of protective services for adults and the premises on which this person may be found;

b. The reason the social services official believes the person may be in need of protective services for adults, which may include information provided by other agencies or individuals who are familiar with the person who may be in need of protective services for adults;

c. The person or persons who are responsible for preventing the social services official from gaining access to the person who may be in need of protective services for adults;

d. The efforts made by the social services official to gain access to the person who may be in need of protective services for adults;

e. The names of any individuals, such as physicians or nurses, or other health or mental health professionals qualified to participate in the assessment, who shall accompany and assist the social services official conducting an assessment of the need of a person for protective services for adults;

f. the manner in which the proposed assessment is to be conducted;

g. That the social services official seeks an order solely for the purpose of assessing the need of a person for protective services for adults in accordance with the provisions of section four hundred seventy-three of this article and applicable regulations of the department;

h. That no prior application has been made for the relief requested or for any similar relief, or if prior application has been made, the determination thereof, and the new facts, if any, that were not previously shown which warrant a renewal of the application.

Any allegations which are not based upon personal knowledge shall be supported by affidavits provided by a person or persons having such knowledge.

F. Once the Assessment Ordered By the Court Is Completed, What's Next?

Following the assessment, there are several possible outcomes. These include:

- Based on the assessment, a determination is made that the person is not APSeligible. The APS case can be closed and any appropriate referrals for other assistance or services can be offered to the person.

- Based on the assessment, a determination is made that the person is APS-eligible, but has the capacity to make decisions whether or not to accept services. An APS services plan is developed and services are offered to the person. The person then decides whether or not to accept services.
- Based on the assessment, a determination is made that the person is APS-eligible, and that the person appears to lack capacity to make decisions, including whether or not to accept services. If the district believes that there is a serious threat to the person's wellbeing, and that the person is incapable of making decisions on his or her own behalf because of impairments, the social services official has a responsibility to pursue appropriate legal intervention in accordance with law. Remember, the district

must employ the least restrictive intervention necessary to effectively protect the adult. The immediacy and seriousness of the threat to the individual will determine whether crisis intervention procedures and/or other legal procedures are warranted. 18 NYCRR section 457.6(a).

Issuance of an order to gain access is for the purposes of assessment only. SSL section 473-e, which governs orders to gain access to persons believed to be in need of APS, states at subdivision five: "The provisions of this section shall not be construed to authorize a social services official to remove any person from the premises described in the application, or to provide any involuntary protective services other than to assess a person's need for protective services for adults." If the social services official believes that an involuntary intervention is needed, such intervention must be based on separate legal authority in accordance with section 473 of the SSL and 18 NYCRR section 457.6.

G. Model Forms

Please see Appendix A for model forms for an Access Order Petition and an Access Order.

These are meant only as samples. APS staff should consult their county or agency attorney.

H. Share with Us Your Best Practices Related to this Topic!

We are interested in hearing from local districts and others in the field what the best practices are relating to this topic. Please share your information with your Bureau of Adult Services representative or to:

Alan Lawitz
Director, Bureau of Adult Services
New York State Office of Children & Family Services
Room 333, North Building
52 Washington Street
Rensselaer, N.Y. 12144
Alan.Lawitz@ocfs.ny.gov

ACCESS ORDER PETITION

STATE OF NEW YORK: COUNTY OF NEW YORK

X----------X

In the Matter of the Application of _____ as Chief Deputy Commissioner of Social Services of _____ County, For an Order Pursuant to Social Services Law Section 473-c to Gain Access to _____ a Person believed to be in Need of Protective Services for Adults	APPLICATION FOR ORDER PURSUANT TO SECTION 473-c OF THE SOCIAL SERVICES LAW Index No. _____

X----------X

STATE OF NEW YORK, COUNTY OF _____ SS:

_____ being duly sworn, deposes and says that:

1. I am the Chief Deputy Commissioner of the County Department of Social Services, with offices at _____, New York. I am a social services official duly authorized to apply for an order to gain access to a person believed in need of protective services for adults pursuant to Social Services Law §473-c of the New York State Social Services law.

2. Upon information and belief, the source of information being _____ _____ Caseworker, _____ County Department of Social Services and

_____ Director of Case Enforcement, Village of _____ there is reasonable cause to believe _____ is an adult person of approximately 75 years of age who may be in need of protective services for adults and who may be found on the premises located at _____ New York. The affidavits of _____ and _____ both executed on November 17, 200_, are attached hereto as Exhibits "A" and "B" respectively.

3. The reasons for concern and the belief that _____ may be in need of protective services for adults and as set forth more fully in Exhibit "A" and "B" are as follows:

a) _____ resides at _____, New York, a residence which is without heat, electric, hot water or operative toilet facilities and which has been substantially boarded up by the Village of _____. On September 5, 200_, said residence, owned by a person other than _____ _____ was declared by _____ in his official capacity, to be unfit for human habitation under § 55-45A(2)(a) of the _____ _____ Village Code. In his affidavit dated November 17, 200_, _____ _____ has stated that in his opinion said premises are in such condition as to constitute an imminent danger or threat of serious physical harm to any occupant thereof, and will continue to pose such a threat until substantial repairs are made and appropriate corrective action taken.

b) _____ , has exhibited conduct which indicates she may have sufficient impairment of judgment to plan appropriately for herself and her

well-being, and is therefore possibly in need of protective services for adults. Said conduct, as described in the affidavit of _____, executed on November 17, 200_, includes her refusal to accept the fact that she is not the owner of said premises and her conversations about "resetting" bodies at _____ Body Shop.

4. The person who is responsible for preventing the _____ Department of Social Services from gaining access to _____ is herself.

5. The _____ County Department of Social Services has attempted to gain access to _____ on November 3, 200_,; November 5, 200_; November 10, 200_; November 12, 200_; November 13, 200_; November 14, 200_; November 15, 200_; and November 16, 200_. Diligent efforts to access _____ to assess the need for services on a voluntary basis have been unsuccessful.

6. The names of the individuals who shall accompany and assist the social services official conducting an assessment of the need of _____ for protective services for adults are as follows:

a) _____, Adult Protective Services Caseworker, _____ County Department of Social Services.

b) _____, M.S.W., Clinic Administrator, _____ Mental Health Clinic.

c) _____, M.D., Medical Director, _____ Mental Health Clinic.

d) _____, officer or officers of the _____

_____ County Police Department.

7. The proposed assessment shall be conducted by entering said _____ apartment at _____, New York and conducting an inspection of the physical environment as well as an interview with _____ to determine if she is in need of adult protective services, to wit:

a) Assistance in moving from a situation which is, or is likely to become hazardous to her health and well-being.

b) Arranging for medical or psychiatric services to safeguard and improve her circumstances.

c) Arranging, if necessary, for commitment, guardianship or other protective placement by referral to appropriate agencies.

In addition, an assessment will be made to determine if _____ has the capacity to understand her situation and plan accordingly with or without the acceptance of services from the _____ County Department of Social Services or other agencies.

8. The order of access sought herein is solely for the purpose of assessing the need for protective services for adults in accordance with the provisions of Section 473 of the Social Services Law and applicable regulations of the _____ County Department of Social Services.

9. No prior application has been made for the relief requested herein.

WHEREFORE, your applicant requests that this Court issue an order pursuant to Social

Services Law 473-c, authorizing _____, Chief Deputy Commissioner,

_____ County Department of Social Services;
_____, M.S.W., Clinic Administrator; _____

Mental Health Clinic; accompanied by a police officer or officers, to enter the premises

_____, Village of _____, State of New York, to conduct

an assessment to determine whether _____

is in need of protective services for adults.

_____

Sworn to before me this 19th day of November, 200_

_____

Notary Public

Notary Public State of New York

Commission Expires March 30, 200_

ACCESS ORDER

At a Trial Term Part 2 of the Supreme Court
To the State of New York, held in and for
The County of _____
At the County Center, _____,
New York, on the 19th day of November,
200_.

P R E S E N T:

HON. _____, Justice.

X----------X

In the Matter of the Application of _____, ORDER PURSUANT TO

Chief Deputy Commissioner of Social Services of _____ § 473-c SSL
_____ County, _____, DIRECTING ACCESS TO

Petitioner, PERSON WHO MAY BE IN

To Gain Access to _____, NEED OF PROTECTIVE

Gain Access to _____, SERVICES FOR ADULTS
A Person believed to be in Need of Protective Services for Adults Index No. _____

X----------X

For an Order Pursuant to Social Services Law §473-c to

On reading and filing the annexed affidavit of _____, Chief

Deputy Commission, _____ County Department of Social Services, executed

on the 19th day of November, 200_; and the affidavit of _____,

Director of Code Enforcement, _____, Caseworker,

_____ County Department of Social Services, executed on the 17th day of November, 200_, from which it appears there is reasonable cause to believe that there may be a person in need of protective services for adults and that the said _____, may be found at _____, New York, and that access to the said _____ has been refused, it is hereby

ORDERED that, _____, Chief Deputy Commissioner, _____ County Department of Social Services; _____, Caseworker, _____ County Department of Social Services, Mental Health Clinic; and _____, M.D., Medical Director, _____ Mental Health Clinic, accompanied by a police officer or officers, are hereby authorized to enter the premises _____, New York to conduct an assessment pursuant to Social Services Law §473-c, to determine if the said _____ is in need of protective services for adults; and it is further ORDERED that issuance of this order shall not be construed to authorize a social services official to remove any person from _____, New York or for a social services official to provide any involuntary protective services to _____, other than to assess her need for protective services for adults; and it is further

ORDERED that this access order shall be executed with two (2) days of its issuance; and it is further

ORDERED that within two (2) business days after the execution of this access order, _____, Chief Deputy Commissioner, _____ County Department of Social Services, shall file a report with this Court detailing the outcome of the authorized assessment of _____ with respect to her need for protective services for adults; and it is further

ORDERED that the police officer or officers accompanying the said social services official may break open the door to gain entry if, after notice of his or her authority and purpose, he or she is refused admittance.

ENTER,

_____

J.S.C.

GRANTED

Identifying and Making Referrals for Appropriate Services: Best Practices Guidelines

I. Purpose

The purpose of this document is to provide best practice guidelines as well as a summary of the applicable law and OCFS policy guidance to assist local district Adult Protective Services (APS) staff when making services referrals.

II. Introduction

Local departments of social services (LDSS), through the efforts of Adult Protective Services, are charged with receiving and addressing APS referrals from various sources, both professionally and directly from the community, including family members.

Some referrals that APS receives do not warrant an investigation; some are simply "information and referral" which APS staff provides, based on the specific concerns of the referral source. Examples of this include providing telephone numbers for other agencies within the community and explaining the criteria to receive APS intervention.

APS initially evaluates the reported situation in a timely manner and determines whether the person is eligible to receive services. APS looks for risk factors affecting the safety and wellbeing of the person. For clients with decision-making capacity, the willingness of the person to receive services is a key factor in the case remaining open for any length of time.

Once eligibility for services is confirmed, a thorough assessment of risk and need is done within 60 days of referral date. Thereafter, ongoing assessments are conducted on open cases every six months.

Assessments are individualized to meet the specific needs of each client. Often, this means making a referral to community-based agencies that provide the identified service to keep the client safely residing in the home (when possible). Assessments reflect the current needs and risks of the client, so service plans change accordingly.

In some APS cases, the needs of the client are such that they do not require the assistance of community service providers. Some examples of this include monthly home visits by an APS caseworker for safety monitoring purposes, formal financial management of Social Security funds through Representative Payee services, and informal financial management conducted by the caseworker.

Some LDSSs have case aides or similar staff positions who can do shopping and errands for clients who are ineligible for Medicaid-funded home care or personal care. Staff can also assist with transportation to appointments for persons with no other available transportation options.

APS also serves involuntary persons who need assistance. This population is handled differently due to legal considerations, and will be addressed in section VI.

III. Risk Factors and Services Offered to Address the Needs of APS Clients

There are numerous risk factors that APS clients face, including: lack of food and clothing;

- lack of shelter leading to homelessness or displacement;
- lack of medical care, including mental health treatment;
- inability to adequately access benefits (Medicaid, SNAP, Temporary Assistance and Veteran's Administration, Social Security Administration);
- correction of home environmental factors (heavy duty cleaning and/or insect/rodent extermination, safety related home maintenance repairs);
- inability to pay bills leading to utility shut off, eviction, etc.;
- lack of transportation to medical and other appointments;
- inability to adequately perform activities of daily living (ADLs);
- social and or physical isolation; and when
- a higher level of care is needed but the client is unable to advocate for self.

APS caseworkers and supervisors must be able to recognize risk factors in the clients they serve. These include signs of physical abuse, self or caregiver neglect, and financial exploitation. Deteriorating conditions should be addressed in a timely manner to avoid a crisis or emergency situation involving medical and or mental health.

Service providers who meet the needs of APS clients come in many forms: some are governmental agencies; some are non-profit or for-profit agencies that serve the community in a variety of ways. Even an informal support system of neighbors, friends and family can serve the APS clients in eliminating or reducing their safety risks from living independently in the community.

Good casework practice includes knowing about the resources in the community and how to access them. It is important for APS to build and maintain good working relationships with other agencies, landlords, home repair services, deep cleaning services, hospitals, other medical facilities, home health agencies, homeless shelters, food pantries and soup kitchens, other departments within LDSS, domestic violence services, substance abuse services, law enforcement and counseling and case management services. All these entities serve APS clients in reducing risk and increasing independence.

18 NYCRR § 402.1 provides that the responsibilities of each LDSS include:

> Maintaining a resource inventory of services provided by the social services district and of services available from other public and private community agencies.

It is therefore important that all caseworkers, especially new ones, have access to an up-todate inventory or list of service providers in the community. Experienced supervisors and caseworkers may be the best resource for the APS unit, especially for new staff. Another good practice is for APS supervisors to have periodic meetings with administrators of service providing agencies in the community. Engaging in community coalitions, task forces, and committees is a good way to develop and sustain relationships with APS service providers. This type of engagement is more likely to create and sustain collaborations that produce the best outcomes for APS clients. Ongoing outreach is a good preventative practice that helps to keep the lines of communication open. Some examples of this are community sponsored wellness fairs, Office for the Aging (OFA) social events, and Single Point of Entry (SPOE) meetings. OCFS provides LDSSs with brochures, posters and other materials for the purposes of outreach and public education.

Keep in mind, although the community service providers are there to support APS clients, case outcomes can be affected by factors such as the degree of client cooperation, funding availability and staff resources.

In some instances, a Memorandum of Understanding (MOU) between APS and another agency can keep the roles and expectations clear.

IV. Assessment / Service Plan: The Road Map to Success

The written service plan/assessment is the best way to identify exactly what the client's risks are and what services are needed to correct the situation. It also offers the opportunity to track the changes (improvements or setbacks) the client experiences during each six-month period. If new services are required or if current services can be discontinued, the service plan acts as a record for these changes. Specific details as to who the service providers are and what their roles are should also be included in the written plan. Objectives should be clearly defined.

The National Adult Protective Services Association (NAPSA) created a guide called *Adult Protective Services Recommended Minimum Program Standards*. It includes the following guidelines regarding service plans and delivery to APS clients:

- Coordination of services with agencies and community partners
- Focus on case planning that maximizes client's independence

- Use family and informal support systems first, as long as it is in the best interest of client
- Use the least restrictive services and community based rather than institutionally based services
- Engage in voluntary service planning with client as much as possible
- Document activities in thorough, concise manner

The OCFS Adult Services Practice Model (see Appendix B) contains similar statements of practices and strategies relating to assessment and services planning.

OCFS provides an Online New Worker Orientation that serves to prepare and supplement mandated training for new APS caseworkers. Embedded throughout the manual is information relevant to identifying and making referrals for appropriate services. In particular, Section VI, "Accessing Services for Clients," details the philosophy, expectations and guidelines for successful casework on this topic.

Once eligibility has been determined, a completed and signed APS Assessment/Services Plan is required to be submitted for supervisory approval within 60 days of the date of referral. However, the service needs of individuals who are being assessed for APS must be addressed promptly and appropriately regardless of the date of completion of the assessment/services plan. [18 NYCRR 457.2 (b) (4) (ii)]

> Accordingly**,** potential health risks, environmental hazards or suspected acts of abuse, financial exploitation and neglect of clients by other persons must be promptly and aggressively investigated and addressed. Decisive action also must be taken during the assessment period to promptly address unmet basic client needs for food, clothing, shelter, medical treatment and homecare. [96 ADM 18, Section IV. B]

Confidentiality in record keeping is a right that every APS client should expect. Steps should be taken to ensure that what is written in a service plan (or progress notes) is protected. Even when discussing the case with other service providers, it is important that caseworkers and supervisors carefully choose what they share with others, as it may violate the confidential rights of clients. See 92 INF 26 for further guidance.

V. Referrals for Residential Care

When making referrals for clients who require residential care, consult with the oversight licensing agency to make sure licensed facilities are in good standing.

A Family Type Home for Adults (FTHA) can be a good choice for APS clients, as it offers 24hour supervision and personal care. These homes serve up to four residents who are not related to the home operator. Each LDSS has an FTHA coordinator who can assist in making referrals. OCFS is the NYS oversight agency for the FTHA program.

Other homes or facilities that serve five or more residents are licensed by the Department of Health (DOH). There is a "Do Not Refer" list that DOH maintains that will assist in making referrals to adult homes, enriched housing, and assisted living programs when a client needs a higher level of care. This list consists of facilities that have received a written notice of an enforcement action based on a violation of law or regulation that creates an endangerment of resident health or safety. The list also includes homes where enforcement action is pending and homes that are currently unlicensed. Some homes on the list have closed voluntarily and are no longer accepting residents for care. The "Do Not Refer" list is periodically updated and can be found at www.health.ny.gov/facilities/adult_care/memorandum.htm. See attached Appendix C.

VI. Serving Involuntary Clients

When an LDSS believes there is a serious threat to an adult's well-being and that the adult is incapable of making decisions on his or her own behalf because of mental impairments, the LDSS has a responsibility to pursue legal intervention. [18 NYCRR 457.6] Only a judge can deem a person to be incapacitated.

In cases where an involuntary protective services intervention is sought, APS must determine that there are no feasible voluntary service alternatives (such as a power of attorney, health care proxy, trust, or less informal supportive arrangements) that will adequately protect the needs of the client.

The legal standard for obtaining a guardianship under Mental Hygiene Law Article 81 requires that:

- the appointment is necessary to provide for the personal needs or to manage the property and financial affairs of the person, or both; and
- the person is deemed incapacitated or agrees to the appointment of a guardian.

If there are no other community resources available, the LDSS commissioner may be named as guardian of the person. The commissioner can be named guardian of person or guardian of property, or both. The commissioner can also be named as co-guardian with another person and share the responsibilities of maintaining the client's safety and wellbeing.

Regardless of the client's capacity, referrals for service should be handled in the same professional manner as with other APS clients.

VII. Share with Us Your Best Practices Related to this Topic

We are interested in hearing from local districts and others in the field about best practices relating to this topic. Please share them with your bureau representative or send them to:

Director, Bureau of Adult Services
New York State Office of Children and Family Services
52 Washington Street
Room 333 North Building
Rensselaer, NY 12144

Appendix A: Related ADMs, INFs and Social Services laws in regard to Identifying and Making Referrals for Appropriate Services

90-ADM-40 - ***Client Characteristics*** provides a list of services that are common to what APS offers:

1. APS arranges for adequate food, clothing, shelter.
2. APS arranges for medical care, Mental Health care *(including substance abuse and domestic violence treatment).*
3. APS arranges for accessing and maintaining benefits (SNAP, MA, VA, etc.).
4. APS arranges for correction of environmental hazards.
5. APS arrange for formal or informal financial management.
6. APS arranges for in-home care for ADL's (including transportation).
7. APS arranges for other community resources as support (family, friends, other).
8. APS arranges for hospitalization and payment if needed.
9. APS arranges for higher level of care if needed. APS also offers the following:
10. APS arranges for coordination with other service providers.
11. APS conducts regularly scheduled home visits.
12. APS makes referrals to law enforcement and justice system and arrange for court involvement.

Detailed references to correspond with the previous 12 items:

1. **Adequate Food, Clothing and Shelter**
    - **SSL 457.5** – Duties and Responsibilities (c) Additional duties, 1. emergency assistance
    - **SSL 457.7** – Coordination and utilization of Community Resources – other DSS departments *(i.e., housing),* income maintenance and services
    - **SSL 461** – Home Delivered Meals: 461.2 Eligibility: LDSS determines eligibility and coordinates arrangement with provider

2. **Medical Care, Mental Health Care** (including substance abuse* and domestic violence counseling)
    - **SSL 457.7** – Coordination and utilization of Community Resources – medical assistance
    - **SSL 462** – Non-residential Services for Victims of Domestic Violence
    - **83-ADM-024** Medical Assistance o Documentation needed for medical assistance is required, however for some APS clients, this may not be available.
        - o Alternative sources for APS clients are therefore allowed. o LDSS is responsible to determine capacity of client.
    - **98-INF-5** APS Mental Health Evaluation Referral Instrument o A tool for APS to use when making referral for MH services o Addresses ability to make reasonable decisions, capacity to understand consequences of decisions, identification of functional and cognitive deficits of clients

3. **Accessing and Maintaining Benefits**
    - **SSL 457.7** – Coordination and utilization of Community Resources – Services - Supplemental Nutrition Assistance Program, Medicaid, Veteran's Administration, Social Security Administration

4. **Correction of Environmental Hazards**
    - **SSL 460.1-2** – 1. Homemaker Services *(one-time deep cleaning, insect and rodent extermination and ongoing home making services)*; 2. Conditions, rights and duties, coordination with casework activities and caseworker responsibilities

5. **Formal or Informal Financial Management FM)**

SSL 457.5 – 1. Duties and Responsibilities (c) Additional Duties, 2. Alternate Social Security (SS) payment procedures i.e., Protective Payee and 3. Rep Payee services for SS benefits

- **SSL 457.7** - Coordination and utilization of Community Resources APS Service Delivery Network including: accounting
- **83-ADM-15** Establishment of Financial Management System to Serve APS Clients
    - o Addresses the need for vulnerable adults to manage financial affairs to avoid crisis situations (such as utility shut-offs and homelessness) and avoid institutional placement.
    - o Utilize "least restrictive environment" attitude toward FM
    - o Possible to use community resources, such as other public or private agencies, family, friends to provide FM
- **79-INF-008** Financial Management Procedures for Individual Clients

o LDSS is responsible to provide FM vulnerable adults who need this. LDSS must monitor and document formal and informal procedures in both case record and local accounting unit. o Financial management vs. case management

- o LDSS must determine the needs of the client and utilize 1. Income maintenance, 2. Medical assistance, and 3. Services (in coordination) to meet client's needs.
- o LDSS should seek assistance from family members of client. Also this service can be provided by an authorized community agency. o NYS DSS, SSA and Mental Hygiene Law (Sections 77 and 78) support FM policies.
- o Detailed information regarding formal and informal methods of FM, including Rep Payee

6. **APS Services arrange for in home care for ADL's** (including transportation)

- **See SSL 460.1-2** Homemaker Services
- **86-INF-032** Expanded In-Home Services for the Elderly Program o EISEP covers non-medical in-home services for elderly.

7. **Other Community Resources as Support** (family, friends, other)

- **SSL 457.5** – Duties and Responsibilities (c) additional duties

8. **Hospitalization and Payment** (if needed)

- **SSL 457.5** – Duties and Responsibilities (c) additional duties
- **SSL 457.7** – Medical Assistance and Accounting
- **92-INF-054 APS** Access to Hospital Records for the Purpose of Conducting APS Investigation on Behalf of Persons Referred by

Hospitals o Based on Public Health Law, SS Law, DOH regulations, DOH permits the release of records, as needed by APS to arrange for recommended services, as needed.

- **92-INF-055** APS Model Hospital Agreement o Regarding discharge planning to ensure safety of client

9. **Higher Level of Care** (if needed)

SSL 489 – Adult Care Facilities for Family Type Homes for Adults (FTHA) – FTHAs serve as a potential housing option for APS recipients

- **89-ADM-022** Residential Placement Services (FTHA) o Establishment of FTHA: recruitment, community education, assessment/approval of FTHA operators, ongoing technical assistance for FTHA operators, LDSS supervision of FTHAs, enforcement issues
- **90-ADM-025** Long Term Home Health Care Program o Levels of residential care (excluding shelters)
  - o Services include assessment for appropriate level of care, case management services

10. **Coordination with Other Service Providers**

- **SSL 457.7** – Coordination and Utilization of Community Resources APS Delivery Network
- **83-INF-017** Post Institutional Services Planning Program o Clarify role of LDSS when discharge planning from residential OMH, OPWDD and inpatient psychiatric facilities. Also included are follow-up services in cooperative manner.
- **93-INF-037** APS Model Agreement with OPWDD o Clarification of roles of agencies
- **95-INF-010** APS Model Protocol Between Police and APS o In an effort to improve relationship between LE and APS
- **99-INF-006** APS Confidential Information Sharing Agreement o Developed agreement between APS and OMH and OPWDD o SSL 473.2(a) anticipates the sharing of information (between agencies) to appropriately service the client

11. **Conducts Regularly Scheduled Home Visits**

- **SSL 457.5** – Duties and Responsibilities (b) Contact with APS Client

12. **Referal to Law Enforcement and Justice System and Arrange for Court Involvement**

- **SSL 457.15** – Reports to Law Enforcement Officials - APS mandated report of crime against client
- **SSL 457.15** – Reports to Law Enforcement of Crime Against Client

- **95-INF-20** Family Protection and DV Intervention Act o Details involving what court will be involved, OOPS, etc.
- **99-INF-005** APS Amendments to Penal Law Concerning Vulnerable Elderly Adults o Law becomes more inclusive with vulnerable population o Felonies: Endangering the Welfare of Vulnerable Elderly Adults o Penal Law Sections 260.32 and 260.34

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The following laws, ADMs and INFs address the involuntary client:

- **SSL 457.6** – Serving Involuntary Clients
  (a) Legal Intervention – least restrictive method
  (b) Crisis Intervention – various laws MHL, Family Court, STIPSO (c) Other Legal

SSL 457.11 – Access Orders

 SSL 457.10 – STIPSO

- **88-ADM-023** Serving Involuntary Clients
- **81-ADM-057** Short Term Involuntary Protective Services Order (STIPSO)
- **87-ADM-006** Orders to Gain Access to Persons Believed to be in Need of Protection
- **92-INF-040** Article 81 Guardianship

Appendix B: Adult Service Practice Model

Adult Services Practice Model

Vision

The New York State Office of Children and Family Services' Adult Services ***vision*** is: Vulnerable/Dependent Adults are protected and supported to achieve safety and well-being.

Mission

To improve the safety and well-being of vulnerable/dependent adults

- **Vulnerable Adult:** Adult (age 18 or older) who is the victim of abuse, neglect (including self-neglect) or financial exploitation and who meets Adult Protective Services (APS) criteria
- **Dependent Adult;** Adult (age 18 or older) who needs assistance (e.g., supervision, personal care) in being able to live safely in the community or in community-integrated residential settings such as a Family Type Home for Adults (FTHA).

Outcomes

We will use our practice model to achieve the following ***outcomes*** which we believe will help to achieve our vision:

Safety

Vulnerable adults are protected from abuse, neglect and financial exploitation while their rights to self-determination are respected**.**

Prevention

Through the least restrictive means possible, vulnerable/dependent adults improve their ability to remain safely in the community, to the extent possible.

Well-being

Vulnerable adults who receive services and dependent adults who require residential placement and services receive quality and respectful care which respects their choices in accordance with their wishes and in compliance with the law.

Organizational Effectiveness

Staff are diverse, professionally and culturally competent**.**

Adult Services staff use an adult-centered practice, family-centered to the extent this accords with the client's wishes, and demonstrate partnership.

Values

To achieve these outcomes, we are committed to the following ***values***:

- All adults have the right to be safe and to live with dignity and with self-determination to the extent possible.

- Delivery of services for adults must be individualized, culturally competent, and recognize and honor differences in traditions, heritage, values and beliefs.

- Recognize that the interests of the adult client are the first concern of any service plan or intervention.

- Accountability for actions and results, and data-informed decision-making.

- We value the principles of partnership

  - Everyone deserves respect
  - Everyone needs to be heard
  - Everyone has strengths
  - Judgments can wait
  - Partners share power
  - Partnership is a process

We know that in many cases the job of protecting vulnerable adults is too large and complex for Adult Services to accomplish alone, as many clients require services and benefits from more than one agency or provider. Therefore, we are committed to reach out and encourage our colleagues in other services areas and disciplines to participate in providing services to protect vulnerable adults in coordination with Adult Services, as part of a larger services delivery network.

Adult Services

Adult Protective Services (APS) Criteria:

APS is available without regard to income, to adults 18 years of age or older who:

- because of a physical or mental impairment,
- need protection from actual/or threatened harm due to an inability to meet their essential needs for food, shelter, clothing or medical care, secure benefits for which they are eligible, or protect themselves from physical, sexual or emotional abuse

  active, passive or self-neglect or financial exploitation, and
- have no one available who is willing and able to assist responsibly.

(Optional) Preventive Services for Adults

Provided by districts for at-risk adults who do not currently meet PSA criteria (e.g., they are able to make choices to protect themselves and the immediate danger to them has been stabilized). Among the preventive services that may be provided are:

- Financial management services
- Care management services
- Homemaker
- Housekeeper
- Home management services

Family Type Home for Adults

Recruitment, development, inspection and supervision of Family Type Homes for Adults (FTHA) in accordance with FTHA and Resident Placement Services for Adults regulations.

The following practices, aligned with our values, are intended to achieve the outcomes referenced above. We will prioritize our resources in accordance with these practices.

ADULT SERVICES PRACTICES	STRATEGIES
Engagement	Since most vulnerable adults have the capacity to refuse offered services, best practice is for Adult Services workers to carefully and gently engage clients to make a connection and to offer services.
Assessment	Adult Services workers provide comprehensive assessments of the risks to clients, the clients' needs and desires, and service delivery options available for clients.
Voluntary Services Planning	Services plan is developed with the clients to develop mutual goals to decrease risk and enhance well-being in consultation as appropriate with collaterals and community partners.

Involuntary Services Planning (Where there is a serious threat to an adult's well-being and the adult is incapable of making decisions on his /her behalf.)	• A decision to seek involuntary action is not taken lightly. • Use the least restrictive intervention necessary to effectively protect the client. • Use community-based services rather than institutionally-based services where possible. • Document information needed to justify the use of involuntary intervention. • Do no harm. Inadequate or inappropriate interventions may be worse than no intervention.

Adult Services Strategies for Improving Safety, Well-Being and Staff Competency include:

- initiatives to raise awareness among professionals and the public about how to recognize, prevent and report adult abuse, neglect and financial exploitation;
- initiatives to promote a multidisciplinary response to adult abuse, neglect and financial exploitation;
- frequent regional meetings with local district Adult Services supervisors and workers, and representatives of other agencies and providers involved in Adult Services and issues;
- ongoing technical assistance, training and oversight to assist districts and others to investigate, assess and provide services to vulnerable/dependent adults, in accordance with state law and best practices; and
- development of Best Practices Guides in specified areas.

Emerging Areas of Focus include:

- NYS Cost of Financial Exploitation: collecting data re: costs to clients, cost to agencies in terms of staffing resources and costs of additional benefits and services needed as a result of financial exploitation;
- enhanced Multidisciplinary Teams: pilot programs focusing primarily on prevention and intervention in cases of financial exploitation of vulnerable adults; to be replicated to the extent possible;
- exploring additional tools to assist in screenings of capacity and functional limitation; domestic violence –type dynamics and skills (including safety planning) for APS workers; enhancing Adult Services Investigations (for both APS and FTHA).

Appendix C: "Do Not Refer" list (as of September 2016)

www.health.ny.gov/facilities/adult_care/memorandum.htm

About the "Do Not Refer" List

Section 460-d(11-15) of the Social Services Law requires the Department of Health to maintain a list of all adult homes, enriched housing programs, residences for adults and assisted living programs that have received written notice of an enforcement action based on a violation of an applicable law or regulation that creates an endangerment of resident health or safety, a pending enforcement action against a facility's operating certificate or a determination that the facility is required to be certified as an adult home, enriched housing program or residence for adults. This list is the "do not refer" list. Placement on the "do not refer list" on the Department's website will serve as written notice to the appropriate office of the Office of Mental Health, Department of Correctional Services, State Division of Parole, local services districts as well as hospitals in the locality in which the facility is located.

Referral Suspension

- Section 460-d (11-12) of the Social Services Law, Section 2803-m of the Public Health Law and Section 29.15(i) (1-2) of the Mental Hygiene Law prohibits social services districts and other local government entities, hospitals and inpatient facilities operated or licensed by the Office of Mental Health, Department of Correctional Services and State Division of Parole from making referrals for admission to an adult care facility on the "do not refer list".

Closed Facility:

- Facilities that have closed voluntarily or facilities that were previously on the "do not refer" list and have now closed or are closing.

Uncertified facility:

- Facilities referred to as "questionable operations". These facilities are neither licensed nor certified by the department. These facilities do not meet personal care and supervision standards required by regulation to be provided to residents by the adult care facility.

Changes to the DNRL will be made as needed on this site. Check this site for the most up-to-date information.
If you have any questions or concerns regarding the attached list, please contact Linda O'Connell at (518) 408-1133.