CT Department of Mental Health and Addiction Services

Statewide Services

RESOURCE GUIDE

Updated 1.22.2018

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APPENDIX:
Map of Connecticut/LMHA Locations

Overview of the CT Department of Mental Health and Addiction Services
(Substance Abuse & Mental Health Authority for State of CT)
www.ct.gov/dmhas

Commissioner's Office
410 Capitol Avenue (4th floor)
P.O. Box 341431
Hartford, CT 06134
Main Telephone: 860.418.7000
Community Call Line: 860.418.6962

Mandate:

1. To serve adults age 18 and older with psychiatric or substance abuse disorders, or both, who lack the financial means to obtain such services on their own.
2. To provide Prevention Services to ALL Connecticut citizens.

Department includes:

1. In-patient facilities
   a. Connecticut Valley Hospital (CVH) in Middletown
   b. Blue Hills Hospital (treats substance abuse) in Hartford
   c. Greater Bridgeport Community Mental Health Center in Bridgeport
   d. CT Mental Health Center in New Haven
   e. Capitol Region Mental Health Center in Hartford
2. 15 Local Mental Health Authorities (LMHAs) responsible for community care at local level (see pages 11-12 and Appendix for Map of CT)

Examples of Special Programs: *(see DMHAS website for details)*

1. Acquired Brain Injury Program (ABI)
2. Problem Gambling Services
3. Special Education
4. Young Adult Services
5. Older Adult Services
6. Mental Health HCBS Program (Medicaid waiver)

To apply for services:

1. Mental Health – contact LMHA (see pages 11-12 or visit DMHAS website)
2. Substance Abuse – contact specific program (see DMHAS website)

DMHAS Regional Managers

The state is divided into 5 regions. Listed below are the managers for each region who can assist with finding mental health, substance abuse & problem gambling services.

Region 1:
Manager: Gina Florenzano, 860-418-6659 **gina.florenzano@ct.gov**
Bridgeport, Darien, Easton, Fairfield, Greenwich, Monroe, New Canaan, Norwalk, Stamford, Stratford, Trumbull, Weston, Westport, Wilton.

Region 2:
Manager: Gina Florenzano, 860-418-6659 **gina.florenzano@ct.gov**
Ansonia, Bethany, Branford, Chester, Clinton, Cromwell, Deep River, Durham, East Haddam, East Haven, Essex, Guilford, Haddam, Hamden, Killingworth, Lyme, Madison, Meriden, Middlefield, Middletown, Milford, New Haven, North Branford, North Haven, Old Lyme, Old Saybrook, Orange, Oxford, Portland, Seymour, Shelton, Wallingford, Westbrook, West Haven, Woodbridge.

Region 3:
Manager: Rhonda Kincaid, 860-859-4531, **gina.florenzano@ct.gov**
Ashford, Bozrah, Brooklyn, Canterbury, Chaplin, Colchester, Columbia, East Lyme, Eastford, Franklin, Griswold, Groton, Hampton, Killingly, Lebanon, Ledyard, Lisbon, Mansfield, Montville, New London, North Stonington, North Plainfield, Pomfret, Putnam, Salem, Scotland, Sprague, Sterling, Stonington, Thompson, Union, Voluntown, Waterford, Willington, Windham, Woodstock.

Region 4:
Manager: Rhonda Kincaid, 860-859-4531, **shelly.nolan@ct.gov**
Avon, Berlin, Bloomfield, Bolton, Bristol, Burlington, Canton, East Granby, East Hartford, East Windsor, Ellington, Enfield, Farmington, Glastonbury, Granby, Hartford, Hebron, Kensington, Manchester, Marlborough, New Britain, Newington, Plainville, Plymouth, Rocky Hill, Simsbury, Somers, South Windsor, Southington, Stafford, Suffield, Tolland, Vernon, West Hartford, Windsor, Windsor Locks

Region 5:
Manager: Shelly Nolan, 860.418.6835, **shelly.nolan@ct.gov**
Barkhamsted, Beacon Falls, Bethel, Bethlehem, Bridgewater, Brookfield, Canaan, Cheshire, Colebrook, Cornwall, Danbury, Goshen, Hartland, Kent, Litchfield, Middlebury, Morris, Naugatuck, New Fairfield, New Hartford, New Milford, Newtown, Norfolk, North Canaan, Oxford, Prospect, Redding, Ridgefield, Roxbury, Salisbury, Sharon, Sherman, Southbury, Thomaston, Torrington, Warren, Washington, Waterbury, Watertown, Winchester, Winsted, Wolcott, Woodbury.

Department of Mental Health and Addiction Services
Statewide Services Office
CVH, Beers Hall, 3rd Floor
P.O. Box 351 – Middletown CT – 06457
For further information, contact: Mary Ives, Administrative Assistant
860.262.6957

Overview of Services

Older Adult Services:
Older adults have not been the focus of the public mental health system until recently. To bring more attention to this population, we educate consumers, providers, and other interested individuals about the needs of older adults with respect to mental health and substance abuse.
1.) **The Senior Outreach and Engagement Program.** The Senior Outreach and Engagement Program provides assessment and case management services to at risk older adults (55 and older) by utilizing proactive approaches to identify, engage and refer seniors for various individually tailored community treatment options. Services include education, support, counseling (including in-home counseling) referrals to senior service networks and referrals for treatment. The program goals are to provide the services in a person-centered, strengths-based, culturally sensitive manner that reduces substance misuse, stabilizes behavioral health symptoms and improves quality of life, while assisting the older adult with remaining integrated in the community in the least restrictive setting possible.

The Senior Outreach and Engagement staff also provides education and consultation to local agencies within the designated geographic region to promote integration and collaboration of services for seniors and develop a system of aftercare for older adults identified by the program.

Home and Community-based Services Waiver for Integration, Support and Empowerment:
For individuals with serious mental illnesses, this program is authorized under 1915(c) of the Social Security Act, and is operated by DMHAS with oversight by DSS. The waiver permits the State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community, avoiding institutional care. Service package information is included in this guide.

In addition to the Mental Health Waiver Program described above, the **Nursing Home Diversion and Transition Program** ensures that nursing home placements for DMHAS clients are necessary, appropriate, and safe. PASRR (Preadmission Screening Resident Review) is an integral part of the program. Located at agencies around the state, DMHAS funds Nurse Clinicians and Case Managers who work with clients in nursing homes, hospitals, and the community. Further information is included in this guide.

Acquired Brain Injury (ABI) Services:
Providing integrated community services, ABI Community Services facilitates person-centered recovery and encourages personal empowerment for persons living with acquired brain injury and mental illness. Located at LMHAs statewide, Community Integration Specialists assess eligible individuals and link them with appropriate services. Further information is included in this guide.

Additional CT Resources for Older Adults with Co-occurring Mental Health and Substance Abuse Problems

- **New Prospects: 392 Prospect Street, Bridgeport 06604 Tel: 203.610.6252** http://www.regionalnetwork.org

Serves adult men and women with high severity of substance use and low to moderate severity of mental health symptoms in need of short-term treat of approximately 30 days. Accepts referrals statewide. Equal access to treatment for all persons in need, regardless of race, ethnicity, gender, age, disability, source of payment, and sexual orientation. DMHAS-funded.

- **MCCA McDonough House: 38 Ridgebury Road, Danbury 06810 Tel: 203.792.4515** http://www.mccaonline.com

Serves persons with co-occurring mental and substance abuse disorders, including seniors/older adults. Short and long-term residential treatment. Forms of payment: self-pay (sliding scale based on income & other factors); private insurance; Medicaid.

- **MCCA Trinity Glen: 149 West Cornwall Road, Sharon 06069 Tel: 860.672.6689** http://www.mccaonline.com

Residential long-term treatment (more than 30 days) for men and women, including seniors/older adults, who need substance abuse services. Forms of payment: self-pay or private insurance.

- **SCADD Lebanon Pines: 37 Camp Mooween Road, Lebanon Tel: 860.889.1717** http://www.scadd.org/lebanonPines.html

Long term treatment for men with substance abuse problems. Minimum length of stay is 90 days.

- **Liberation Programs, Inc.: 780 Summer Street, Stamford 06901 Tel: 203.400.0605** http://www.liberationprograms.org

Contact the agency about their outpatient group for older adults: 203.388.1565

- **Wheeler Clinic Senior Substance Abuse Services: Plainville Tel: 860.793.3846** http://www.wheelerclinic.org/adult/substance_abuse_services.php

Serves older adults age 60 plus who have substance abuse issues.

- **Merritt Hall at CT Valley Hospital: Middletown 06457 Tel: 800.828.3396**

Usually treats ages 25-40ish, but older person who has a primary substance abuse diagnosis on Axis I, is without a major psychotic disorder, and can attend 6-7 groups per day may be appropriate; LOS averages 35-40 days; T-19 accepted, but clients usually indigent/uninsured.

- **Greenwich Hospital: Addiction Recovery/ Older Adult Detox Program**
  Tel: 203.863.4673

Geriatric Assessment Resources in CT

Day Kimball Healthcare
Geriatric Care Management Program: 860.779.9270
320 Pomfret Street, Putnam, CT 06260
Adults age 60 and over are eligible. Referral from own physician is suggested. Offers comprehensive evaluation, planning and care coordination for seniors, their families and health care providers. The goal is to assist the elderly and their caregivers to manage chronic illness and high risk conditions in order to improve health, safety and function.
www.daykimball.org

The Department of Veterans Administration (VA)
VA CT Healthcare System
(1) West Haven VA (in- and out-patient programs)
950 Campbell Avenue, West Haven 06516
203.932.5711 (Nursing Home Program ext. 3940)
(2) Newington VA (out-patient programs)
555 Willard Avenue, Newington 06111
860.666.6951
All Veterans enrolled in the VA health care system are eligible for home and community based long term care services.
www.connecticut.va.gov/

Hospital of Saint Raphael, New Haven (now part of YNHH)
Healthy Aging Hotline for Senior Services: 203.789.3275 (variety of services)
www.srhs.org/body.cfm?id=43

Hospital of Central CT, New Britain and Southington
New Britain campus: 860.224.5267 (in & outpatient services for mental illness & substance abuse & Older Adult Programs)
Southington campus: 860.276.5293 (Center for Health Aging)
www.thocc.org/services/medical/geriatric.aspx

The Institute of Aging, Fairfield
203.396.1240
175 Jefferson Street, Fairfield, CT
Specializes in examining, diagnosing and treating cognitive or memory function. Assessments available in the client's home, at the IOA clinic, or other location convenient to the client. Clients seen within 2 weeks of initial contact. Accepts Medicare, long-term care insurance, or private pay.

www.ioaging/services/senior_assessment_service_sf.html

Institute of Living/Hartford Hospital, Hartford
Geriatric Program (in & outpatient)
The Institute of Living Assessment Center 860.545.7200 or toll-free 1.800.673.2411
80 Seymour Street, Hartford, CT 06102
Work in consultation with own physician.
www.instituteofliving.org/Programs/GeriatricServices.htm

Geriatric Assessment Resources in CT *continued*

Masonicare Primary Care Physicians, Wallingford
67 Masonic Avenue, Wallingford, CT 06492
General Healthcare and Well-being Services
203.679.5900 or toll-free 1.800.528.6664
A geriatric assessment is an outpatient appointment, which usually takes approximately 1-1/2 to 2 hours. It includes a follow-up report to the patient's own physician.
www.masonicare.org

Saint Francis Hospital, Hartford
860.714.4749
114 Woodland Street, Hartford 06105
Provide comprehensive geriatric evaluations.
www.stfranciscare.org

UConn Health Center, Center on Aging, Farmington
Main: 860.679.3956
Appointments: 860.679.8400 (UConn Geriatric Associates)
Office hours Monday-Friday, 8-5.
263 Farmington Avenue, Farmington, CT 06032
Provides primary care for older adults on the Farmington campus and other locations; consultative and specialty services also available.
www.uconn-aging.uchc.edu/

Yale New Haven Hospital, New Haven
Dorothy Adler Geriatric Assessment Center: 203.688.6361
874 Howard Avenue, New Haven, CT
Person receives a comprehensive medical exam and diagnostic testing is done as an out-patient at YNHH or at the patient's preferred site. Team works closely with patient's own physician.
www.geriatrics.yale.edu/clinical/index/html

Mental Health Waiver
Working for Integration Support and Empowerment

(Revised as of October 13, 2016)

The waiver program for individuals with serious mental illness encompasses the recovery orientation adopted by the Department of Mental Health and Addiction Services (DMHAS), but also signals new directions in the community treatment of people with serious psychiatric disabilities because of its emphasis on:

- Intensive psychiatric rehabilitation provided in the participant's home, and in other community setting;
- Attention to both psychiatric and medical needs;
- Emphasis on wellness and recovery;
- Person-Centered Planning leading to development of an individualized Recovery Plan; and
- Use of peer supports provided by people trained and certified in rehabilitative care, who know from first-hand experience about recovery from mental illness.

The waiver program, authorized in §1915(c) of the Social Security Act, permits the State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutional care. Waiver services complement and/or supplement services available to participants through the Medicaid State plan and other federal, state and local public programs, as well as natural supports that families and communities provide. The Waiver is operated by the DMHAS with oversight by the Department of Social Services (DSS). The waiver program serves eligible individuals transitioning out of nursing facilities or who are at risk for this level of care. Each person enrolled in the waiver participates in a Person-Centered Planning process leading to the development of an individualized Recovery Plan. The plan, developed collaboratively with the participant and a DMHAS Community Support Clinician includes one or more of the following services:

Rehabilitative Services and Support Services:

- **Community Support Program (CSP)** – A flexible, team-based approach to community rehabilitation.
- **Peer Support** – An alternative or "step-down" and follow-up to CSP provided by a trained and certified peer specialist.
- **Recovery Assistant** – homemaker, companion, personal care, and in-home respite services deigned to help a participant maintain his/her own home.
- **Supported Employment** – an effective array of mental health supports designed to help participants find and sustain competitive employment.
- **Transitional Case Management** – services provided during the weeks prior to, and immediately following discharge from a nursing home, to help locate and set up a suitable apartment or other living arrangement.

Residential Based Services:

- **Assisted Living Agency –** Personal care and services provided in a licensed community care facility, provided to residents of the facility. This service includes 24-hour on-site response staff.
- **Community Living Support Services –** Support Services, including overnight supervision, necessary to enable a participant to live in a shared apartment, or independent residential setting in the community.

Other Ancillary Services:

- **Specialized Medical Equipment**
- **Home Accessibility Adaptations**
- **Non-medical transportation**

Client Eligibility for Mental Health Waiver

Participants must meet all of the requirements of Section 1, and one of the requirements of Section 2:

Section 1 (all of the following five requirements)
1. An adult, 22 years of age or older;
2. Who is Medicaid eligible;
3. Meets the Medicaid State Plan criteria for nursing home level of care;
4. Voluntarily chooses to participate in the waiver; and
5. Has a diagnosis of serious mental illness as defined by State of Connecticut PASRR policy.

Section 2 (one of the following three requirements)
1. Is currently a resident of a nursing facility;
2. Is a participant in Money Follows the Person (MFP); or
3. Has a psychiatric history, impairment and service needs as evidenced by the following:

Is currently experiencing two or more of the following circumstances due to serious mental illness:
- Has been recommended to take, or currently uses prescribed medication to control psychiatric symptoms;
- Is unable to work in a full-time competitive employment situation;
- Requires on-going supervision and support to maintain a community living arrangement;
- Is homeless, or at-risk for homelessness;
- Has had, or will predictably have, repeated episodes of decompensation such as increased symptoms of psychosis; self-injury; suicidal/homicidal ideation; or psychiatric hospitalization.

***Additionally*……**

- Has a level of risk to self or others that a licensed or license-eligible mental health professional has determined can be managed safely in the community.
- Have the following core services needs, if living in the community:
  1. One-on-one rehabilitative activities in the home or in other community settings to assist in managing psychiatric, substance use, or medical problems, and in meeting requirements of everyday independent living; and
  2. Support Coordination to assist in developing and implementing a Recovery Plan that ensures psychiatric and/or medical needs are met.

MH Waiver Application – Referral Process

1. Application/ Request for Service submitted to MH Waiver Program

2. Application/Request for Service reviewed by MH Waiver Manager or designees for eligibility (e.g., documentation of Mental Health diagnosis; has ADL needs and Cognitive Impairments exacerbated by SMI).

3. Medicaid Husky-C eligibility verified by DSS

4. Assessment conducted by a Waiver Community Support Clinician (CSC) to confirm eligibility.

5. Recovery Plan developed including: services needed and assurance that services can be safely provided within the authorized cost cap.

6. Plan and corresponding services submitted by Waiver staff to DSS for approval.

7. Recovery Plan implemented with Waiver service providers selected by participant.

8. Payment for Services as outlined in Recovery Plan are authorized by Waiver staff-and reviewed semi-annually.

Contact Mary Ives (860) 262-6957 or toll free 1-866-548-0265 or mary.ives@ct.gov for further information

Department of Mental Health and Addiction Services
Nursing Home Diversion and Transition Program (NHDT)

Goal: To ensure that DMHAS clients are not placed in, or remain in, nursing homes unless necessary, appropriate, and safe. Understanding the process of Preadmission Screening Resident Review (PASRR) is an integral part of the program.

Objectives:

1) Divert DMHAS clients from nursing home placement unless absolutely necessary (i.e.; person could not be served in the community due to a need for continuous skilled nursing services related to a chronic condition, or requires short-term rehabilitation for a medical condition).

2) Transition back to the community DMHAS clients who reside in nursing homes and no longer require the level of care.

NOTE: Clients served under the NHDT Program may receive DMHAS services and/or Medicaid State Plan Services. They are not considered clients of the Mental Health Waiver Program.

NHDT Program Structure: Nurse Clinicians and Case Managers are located at DMHAS-funded agencies and work with clients in designated geographical areas. Staff is supervised by the DMHAS NHDT Program Manager.

Staff Functions:

Nurse Clinicians:

- Act as liaisons for clients eligible for DMHAS services through Local Mental Health Authorities, as well as other initiatives (e.g., Money Follows the Person).
- Work directly with nursing homes to determine the appropriate level of care for DMHAS clients and assist in developing transition plans.
- Link with designated nursing homes to monitor and track length of stay for possible transition to the community for clients with a short-term approval or expressed desire to move to a less restrictive setting.

Case Managers:

- Support the work of the Nurse Clinicians as above.

QUESTIONS?

Sherry Marconi, Program Manager
CVH - Beers Hall – 3rd floor
P.O. Box 351
Middletown, CT 06457

Office: 860.262.6953
sherry.marconi@ct.gov

DMHAS Acquired Brain Injury Services

Definition of an Acquired Brain Injury

An injury to the brain that has occurred after birth, which results in any combination of focal and diffuse central nervous system dysfunction, both immediate and/or delayed at the brain stem level and above. This dysfunction is acquired through the interaction of any external force and the body, including blows to the head and violent movements of the body (Traumatic Brain Injury), as well as through oxygen deprivation; infection; toxicity; surgery; and vascular disorders not associated with aging. *This dysfunction is not congenital, developmental, or degenerative.*

Regional Community Integration Specialists (CIS) provide assessment services to individuals who are 18 years of age or older who may have incurred a brain injury and assist in linking them to appropriate services. If the individual has a qualifying brain injury, as provided by appropriate documentation, and is connected to DMHAS, the individual is eligible for the following services as appropriate:

- Ongoing Consultation Services
- ABI Substance Abuse Services
- ABI Vocational Services
- Community Residence and Transitional Housing and Living Subsidy
- Training and Education
- Advocacy Supports

Referrals can be made by calling the DMHAS ABI Central Intake @ 860.262.6725. The Referral Form can also be accessed via the DMHAS website www.ct.gov/dmhas under "Programs" and faxed to the DMHAS ABI Central Intake @ 860.262.5852.

Regional CIS Staff for DMHAS ABI Services

Geographic Area	Community Integration Specialist
Lower Fairfield County	**Sue Petrik, LCSW, CBIS** 203.551.7035 or susan.petrik@ct.gov
Greater Bridgeport	**Sue Petrik, LCSW, CBIS** 203.551.7035 or susan.petrik@ct.gov
Greater New Haven/ Middletown/Meriden	**Elizabeth Van Leer, LCSW, CBIS** 203.974.7260 or elizabeth.vanleer@ct.gov
Southeastern CT	**William McEwen, LMSW, CBIS** 860.859.4694 or william.mcewen@ct.gov **Rachel Epstein, LMSW** 860.456.2261 x3640 or Repstein@usmhs.org
Northeastern CT	**Brooke Corbett, LCSW** 860.359.3640 or brooke.corbett@ct.gov
Greater Hartford Area	**Agnes Black, LCSW, CBIS** 860.293.6302 or agnes.black@ct.gov **Erin Egan, LMSW** 860.840.1414 or erinegan@ct.gov
Greater Torrington/ Danbury/Waterbury	**Sarah Carlson-Allwood, LCSW** 203.805.6425 or sarah.carlson-allwood@ct.gov **Rita Brzozowski, LCSW** 860.496.3792 or rita.brzozowski@ct.gov

Additional Information on ABI Services

CT Department of Social Services – Medicaid ABI Waiver

The CT Department of Social Services (DSS) oversees the Medicaid ABI Waiver which provides a range of non-medical, home and community-based services to support adults with ABI (*again, not a developmental or degenerative disorder*) in the community.

Eligibility Criteria:

- Adults age 18-64;
- Must be able to participate in the development of a service plan in partnership with a DSS Social Worker, or have a Conservator to do so; and
- Must meet all technical, procedural and financial requirements of the Medicaid program, or the Medicaid for Employed Disabled program.

To learn more about the ABI Waiver or to obtain an ABI waiver request form, call the DSS office nearest to your home:

3580 Main Hartford	860.723.1030
699 East Middle Turnpike, Manchester	860.647.5811
30 Christian Lane, New Britain	860.612.3565
194 Bassett Street, New Haven	203.974.8038
117 Main Street Ext., Middletown	860.704.3040
925 Housatonic Ave, Bridgeport	203.551.2881
1642 Bedford Street, Stamford	203.251.9418
401 W. Thames Street, Unit 102, Norwich	860.823.3380
676 Main Street, Willimantic	860.465.3500
249 Thomaston Ave, Waterbury	203.597.4145
342 Main Street, Danbury	203.207.8955
62 Commercial Blvd, Torrington	860.496.6900

This information is available in alternate formats.
Phone 800.842.1508 or TDD/TTY 800.842.4524

Brain Injury Alliance of Connecticut (BIAC)
200 Day Hill Road, Suite 250
Windsor, CT 06095
http://www.biact.homestead.com

At BIAC, a Brain Injury Specialist is available to provide individualized support, advocacy and guidance to a brain injury survivor, family member, caregiver, or professional to ensure that the often complex and overwhelming challenges experienced following a brain injury are handled more easily and effectively. The BIAC also sponsors approximately 30 Support Groups throughout Connecticut to provide information, support and encouragement to survivors and their loved ones.

Phone: 860.219.0291 **Email:** general@biact.org

Department of Mental Health and Addiction Services
Local Mental Health Authorities (LMHAs)

LMHAs have the authority and responsibility for planning, delivering, and managing a variety of DMHAS-funded mental health services at the local level. Each LMHA covers a specific geographic area of the state. Please check the DMHAS website at www.ct.gov/dmhas to check the LMHA that covers your town.

LMHA	Region/Town	Main Telephone
Southwest CT MH System: • F.S. DuBois Center • Greater Bridgeport MH Center	1-Bridgeport 1-Stamford 1-Bridgeport	203.579.7300 203.388.1600 203.551.7400
BHcare • BHcare Valley Offices (*formerly Birmingham Group Health Services; aka Valley Mental Health)* • BHcare Shoreline Offices *(formerly Harbor Health Services)*	 2-Ansonia 2-Branford	 203.736.2601 203.483.2630
Bridges Community Support System	2-Milford	203.878.6365
CT Mental Health Center i	2-New Haven	203.974.7300
Rushford Center	2-Meriden	203.235.1792
River Valley Services	2-Middletown	860.262.5200
Community Health Resources • Genesis Center • North Central Counseling Services	4-Windsor 4-Manchester 4-Enfield	860.731.5522 860.646.3888 860.253.5020
Inter-Community Mental Health	4-East Hartford	860.569.5900
Capitol Region MH Center	4-Hartford	860.297.0800
Community MH Affiliates	4-New Britain	860.826.1268
United Services	3-Dayville	860.774.2020
Southeastern MH Authority	3-Norwich	860.859.4500
Western CT MH Network • Greater Waterbury MHA • Greater Danbury MHA • Northwest MHA	5-Waterbury 5-Waterbury 5-Danbury 5-Torrington	203.805.6400 203.805.5300 203.448.3200 860.496.3700

DMHAS Crisis Services

LMHA	Telephone
F.S. Dubois Center	203.358.8500 8AM-8PM
Greater Bridgeport MHC	203.551.7501 (24 hours) 1.800.586.9903
Birmingham Group Health Services	203.736.2601
Harbor Health Services	203.483.2650
Bridges	203.878.6365
CT Mental Health Center (CMHC)	203.974.7735 or 974.7713/7714 (9AM-7PM) 203.974.7300 (7PM-9AM)
River Valley Services (RVS)	860.344.2100 or 860.262.5220
Rushford Center	203.630.5305 or 1.800.657.0902
Southeastern MHA (SMHA)	860.886.9302
United Services	860.774.2020 (Dayville) 860.456.2261 (Willimantic) 860.228.4480 (Columbia)
Capitol Region Mental Health Center	860.297.0999
Community Health Resources (CHR)	877.884.3571 or 860.683.8086 (Genesis & North Central Counseling)
Intercommunity Mental Health Group	860.569.5900 (ext 1) M-F 8.30-4.30 After 4.30, calls roll-over to the IOL.
Wheeler Clinic – Community Response Team	860.747.8719
Western CT Mental Health Network	1.888.447.3339 (Torrington) 203.739.7007 (Danbury Hospital Crisis Line) 1.866.794.1121 (Waterbury)

DMHAS Respite Beds

Respite beds are voluntary and may be available as a short-term intervention for a client requiring a 24-hour supportive environment. Respite assists with psychiatric stabilization or as transitional housing to a community setting, but does not provide medical services such as those found in a hospital or nursing home setting. Each respite program listed as its own criteria, including varying length-of-stay.

Respite Program	Description	Contact Information
Rushford (Meriden) **&** **River Valley Services** (Middletown)	Collaborative program between Rushford (10 beds) & RVS (8 beds). *Crisis* respite beds provide high intensity service as alternative to hospitalization with 24/7 staff. *Respite* beds provide less intense	Access beds through RVS Mobile Crisis; Mid-State Hospital ED; Rushford Acute Care; & RVS Acute Care. RVS contact: Mobile Crisis Team 860.262.5220.

	service with 24/7 staff.	Rushford contact: Teresa Kriebeck at 203.235.1792.
Community Mental Health Affiliates (New Britain)	4 beds (2 female; 2 male); cannot be homeless; LOS varies; clients utilizing beds are in crisis in community; stepping down from inpatient hospitalization; or under Jail Diversion.	Tel: 860.224.2044 Fax: 860.224.0667
Greater New Haven Area: New Haven; Milford; Branford; Ansonia/Derby; etc. Managed by Continuum of Care & Communicare depending on location.	New Haven: 9 high intensity crisis/respite beds with 14-day LOS. → 2 beds each located in Milford; Branford; & Ansonia. →	Contact Gretchen Elder (Continuum of Care) at 203.562.2264. Contact Sue Brown (Communicare) at 203. 288.6523. All beds can be accessed through CMHC; YNHH; & Communicare.
Community Mental Health Resources (Manchester-Enfield)	Clients must be physically manageable; age 18+; & enrolled in CHR services; provides brief crisis stabilization & alternative to hospitalization; active programming for individuals who do not meet hospital LOC; not handicap accessible; clients must be able to ambulate without assistance & climb stairs to shower.	607 Enfield St. Enfield, CT 860.741.4392 Can be referred 24/7
Waterbury MHA & Waterbury Hospital Joint Program: Transitional Respite Services	Short-term housing for individuals without housing due to mental health problems; 15 beds of which 7 are forensic; LOS varies based on need; operates 24/7.	Located on grounds of Waterbury Hospital Contact Lisa Murray: 1.866.794.0021
Torrington MHA & MHA of CT Joint Program:	Short-term (90-day) care for people in recovery	Litchfield St, Torrington

Transitional Services	having problems at home; person referred must have case manager to facilitate housing needs.	Contact Marc Trivella at 860.482.0643
Southeast Mental Health Authority (SMHA) (Norwich)	1 bed Brief Care Unit; person must be voluntary & meet DMHAS criteria for services; admission must take place prior to 9 PM; person screened by SMHA Mobile Outreach Clinician to determine appropriateness; LOS 3-5 days.	Contact SMHA Mobile Outreach: 860.886.9302
Sound Community Services, Inc.: Michael Kerr Respite Program (Norwich) Located on grounds of SMHA	5 bed short-term residential living center for persons with MI &/or co-occurring disorders; person must be voluntary & meet guidelines for DMHAS services; screening & assessment through SMHA Mobile Outreach; LOS up to 30 days.	Contact SMHA Mobile Outreach: 860.886.9302
Mercy Shelter & Housing Corporation (Operates CRMHC's Respite Program covering Hartford; West Hartford; Farmington; Avon; Simsbury; East Hartford; Glastonbury; & Wethersfield)	For adults with psychiatric or co-occurring disorders in mental health crisis presenting to or being referred to general hospital ED; referrals made directly to CRMHC Mobile Crisis in Hartford or InterCommunity Mobile Crisis in East Hartford & must include a discharge plan.	6 beds at 118 Main St., Hartford. Contact CRMHC Mobile Crisis at 860.297.0999. Contact InterCommunity Mobile Crisis at 860.569.5900. An additional 4 beds accessed through CRMHC's Managed Service System Division.

DMHAS Homeless Services

DMHAS provides services to persons with a serious mental illness, or a co-occurring mental illness and substance abuse disorder, who are homeless. Services include assertive outreach and engagement with clients, and referrals to case management services.

Contact Alice Minervino at 860.418.6942 or alice.minervino@ct.gov

For a list of emergency homeless shelters, go to.....
http://www.cceh.org/pdf/consolidated_shelter_listing.pdf

Looking for Long Term Care Resources in CT?

If you are interested in information on long term care resources available to both older and disabled younger adults, please refer to the State of CT's Long Term Care Services and Supports/ADRC website @ www.ct.gov/longtermcare.

CT Home and Community-based Services Waivers

CT Home Care Program for Elders* (CHCPE)	**Mental Health Waiver**
1. Age 65+ and Medicaid-eligible. 2. At risk for nursing home placement based on 3 or more critical needs. 3. Contact DSS Community Options Unit: 860.424.4904 –option 4. **If not Medicaid-eligible, may be eligible for state-funded home care services.*	1. Age 22 and over & Medicaid Husky-C - eligible 2. Diagnosis of serious & persistent mental illness *plus* other criteria. 3. Contact 1.866.548.0265. 4. Visit www.ct.gov/dmhas for more information.
Home Care Program for Disabled Pilot	**Personal Care Assistant (PCA)**
1. Ages 18-64; *not* Medicaid & *cannot* have a primary diagnosis of MI. 2. Must have primary diagnosis of degenerative neurological condition. 3. Has 3 or more critical needs or 2 critical needs plus 4 or more cognitive deficits. 4. Contact DSS Community Options Unit: 860.424.4904 – option 4.	1. Age 18 and older; Medicaid-eligible. 2. Has chronic, severe, permanent disability resulting in at least 2 critical needs. 3. Those with MI, MR, and dementia do not qualify. 4. Contact DSS at 860.424.5388.
Acquired Brain Injury (ABI)*	**Dept. of Developmental Services***
1. Age 18 and older. 2. Medicaid-eligible. 3. Must have ABI & meet level of care criteria for nursing home, including intermediate level, or chronic disease hospital. 4. Must be able to participate in development of a service plan. 5. Contact DSS at 860.424.5388. **If person has diagnosis of serious mental illness preceding ABI, may be eligible for DMHAS ABI services. Contact DMHAS ABI Unit @ 860.262.6725.*	1. Age 18 and older with diagnosis of MR. 2. Must meet ICF/MR level of care. 3. Must demonstrate a need for one or more of the waiver services. 4. Must be Medicaid-eligible. 5. Contact DDS eligibility unit at 1.866.433.8192. **more than one waiver available*
Katie Beckett	**Money Follows the Person (MFP)***
1. No age limit, but most participants are children. 2. Must have severe disability. 3. Medicaid-eligible. 4. Contact DSS Alternate Care Unit at 860.424.5404 option 3.	1. Age 18 and over; Medicaid-eligible. 2. Person must be in a nursing home for 90 consecutive days or more; wishes to be in the community; & meets criteria for one of the Medicaid waivers or State Plan Services. 3. Contact DSS at 1.888.992.8637. **Not a waiver program per se.*

Other Resources

Veterans Administration Aid & Attendance Benefit	Statewide Respite Program*
1. For vets (or surviving spouses of vets) who meet service requirements & need help with ADLs; are blind; or a resident of a nursing home due to physical/mental disability. 2. Income & asset limits. 3. Covers home care services & assisted living services in managed residential community. 4. Capped by amount of benefit. 5. Contact CT Dept. of Veteran's Affairs at 860.594.6604.	1. Must be diagnosed with irreversible & deteriorating dementia. 2. Income & asset limits. 3. Covers Adult Day Care; HHA; homemaker; companion; SNF visits &/or ST stays in SNF or ALF. 4. Cost may not exceed $3,500 per calendar year. 5. 20% co-payment of cost for each service. 6. Apply through Area Agencies on Aging at 1.800.994.9422. **If eligible for CHCPE, not eligible for respite program.* ***TIP:*** *Person may also be eligible for $500/family annual benefit from Alzheimer's Assoc. CT Chapter's Respite Fund. No age limit for person or his/her caregiver. Contact: 1-800.356.5502.*
Medicare Home Care Benefit	**Medicaid State Plan Services**
1. MD must sign plan of care for person who has need for at least one skilled service (intermittent skilled nursing; PT or OT or ST & is homebound). 2. In addition to nursing & therapies, covers intermittent HHA when receiving nursing care; medical social work; & DME. 3. No more than 8 hrs/day or 28 hrs/wk of care unless MD indicates need for up to 35 hrs & there is a predictable end to need for more hrs. 4. Consult on eligibility/denials by calling Center for Medicare Advocacy 1.800.456.7790.	1. Physician-ordered as part of a plan of care that is reviewed every 60 days. 2. Begins with referral to community home-health agency. 3. Need W-10 if person discharged from a facility (NH or hospital). 4. Services: nursing; HHA; Pt; OT; ST; & any supplies, equipment or appliances that are medically necessary. 5. Prior authorization required for more than 2 nursing visits a week & more than 14 hours a week of HHA. 6. Contact DSS Regional Offices.

Other Resources

Aging & Disability Resource Centers (Main Phone: 1.800.994.9422)	Area Agencies on Aging (AAA)
1. Independent living philosophy, including self-determination. 2. Single-point of entry system for access to long-term care information, programs & services. 3. Area Agencies on Aging partner with Independent Living (IL) Centers. 4. Currently operational at 5 sites. 5. Aka Community Choices. *See www.ct.gov/agingservices for more information.* ***Note**: CT Community Care, Inc. (CCCI) participates in ADRCs located in Hartford area (860.257.1503, x4369) & the eastern part of state (860.885.2960).*	1. Advocate for elders. 2. Fund certain community services, including CHOICES Program which provides information & assistance on Medicare. 3. Partners with ILs around ADRCs & MFP. 4. 5 agencies as identified below: • Agency on Aging of South Central CT at 203.785.8533. • Western CT Area Agency on Aging at 203.757.5449. • North Central Area Agency on Aging at 860.724.6443. • Southwestern CT Area on Aging at 203. 333.9288. • Senior Resources – Agency on Aging in Eastern CT at 860.887.3561.
Independent Living Centers (ILs)	**State Long-Term Care Ombudsman Program**
1. Independent living philosophy, including self-determination. 2. Partners with Area Agencies on Aging around ADRCs & MFP. 3. Advocates for people with disabilities; tends to be younger pop. with physical disabilities, but includes people with mental illness. 4. Locations in 5 state regions: • Independent Unlimited (North Central CT) at 860.523.5021. • Disabilities Network of Eastern CT at 860.823.1898. • Independent Northwest – Center of IL of Northwest CT at 203.729.3299. • Center for Disability Rights (West Haven) at 203.934.7077. • Disability Resource Center of Fairfield County at 203.378.6977.	1. Advocates for residents of nursing homes, residential care homes & assisted living facilities. 2. Responds to & investigates complaints brought forward by residents, family members, &/or other individuals on their behalf. 3. Offers info & consultation to consumers & providers; monitors state & federal laws & regulations; & makes recommendations for improvements. 4. 3 ombudsman per 3 state regions: • Northern Region Intake at 860.424.5221. • Southern Region Intake at 860.823.3366. • Western Region Intake at 203.597.4181. *See www.ct.gov/ltcop/site/default.asp for more information.*

60 WEST NURSING HOME PROJECT

Contact information:

Erin Leavitt-Smith-Project Manager, 860-262-6966
Loretta Ricker-Assessment Clinician, 860-262-6965
Fax #: 860-262-5832

60 West is a privately owned skilled nursing facility located in Rocky Hill, Ct. The facility has two units: a secured dementia unit and an open long term care unit. There is no secure behavioral unit, though many referrals received have psychiatric history/diagnosis. Referrals for admission originate from the community, inpatient psychiatric facilities and state correctional institutions and must meet nursing home level of care/PASSAR process. They are then directed to the assessment clinician for review. There should be evidence that other traditional nursing homes have been explored with an explanation as to why 60 West is the most appropriate, least restrictive setting for that person. In general, admission candidates may have a degenerative medical condition, such as dementia, Parkinson's, MS, Huntington's disease, a terminal/hospice LOC type diagnosis requiring skilled nursing, level of care services.

A referral is initiated by completing the referral form to 60 West SNF and faxing it to the attention of the assessment clinician (fax # 860-262-5832). In addition to the Ascend/PASSAR process, each person considered for the admission will receive an onsite and a comprehensive assessment, including a risk review. All potential admissions are then approved by a utilization management committee comprised of DMHAS, DOC and 60 West staff.

Nursing Home Placements/Preadmission Screening Resident Review (PASRR)

PASRR PROCESS for Persons with Serious Mental Illness

This is federal law for all states. All applicants to Medicaid-certified nursing homes, regardless of reimbursement source, must be screened to identify a diagnosis of serious mental illness (SMI) and/or a developmental disability. If there is a diagnosis, the person must undergo a Level II evaluation. With some exceptions, this process must be completed prior to nursing home admission. In all cases, to be eligible for nursing home admission, or continued nursing home stay, level-of-care criteria must be met.

The PASRR screen is initiated through Ascend using a password-protected web-based system. Two forms are submitted electronically: (1) Level I, which identifies whether the person has an SMI; and (2) Level of Care Determination. If the Level I is positive for SMI and the person meets nursing home level of care criteria, an Ascend evaluator will meet the person face-to-face to conduct a Level II Evaluation. The Level II is a comprehensive psychiatric evaluation to determine if the person is stable and appropriate for nursing home placement. *NOTE: If the person does not meet nursing home level of care criteria, the Level II is not done.*

Besides preadmission screening, nursing facilities must report to Ascend when a resident with SMI experiences a change of condition/status. A Level II may be required to determine whether the resident requires inpatient psychiatric care provided in a hospital setting.

Ascend tracks those individuals with SMI who receive short-term approvals for nursing home stay to determine if they continue to need nursing home level of care. Ascend may communicate with the DMHAS Nursing Home Diversion and Transition Program, and a Nurse Clinician may follow an individual during their nursing home stay. If the individual no longer meets nursing home level of care, the nurse collaborates with the nursing facility social services staff to transition the person to a less restrictive setting. Again, assistance from this program is only for a person with mental illness (which may include a co-occurring substance abuse disorder).

NOTE: The PASRR process is initiated on-line, and you must be registered with a password.

Ascend website:	**www.ascendami.com & hit link for State of Connecticut**
Ascend Support Specialist to find out status of review:	**1.877.431.1388 ext 3281**

State of Connecticut, Department on Aging list of contact information for the Long Term Care Ombudsman Program:

Mairead Painter State Ombudsman
55 Farmington Avenue
Hartford, CT 06105
Tel. 860-424-5238
e-mail: Nancy.Shaffer@ct.gov or www.ct.gov/LTCOP

Brenda Foreman, Regional Ombudsman
55 Farmington Avenue
Hartford, CT 06105
Intake: 860-823-3366
e-mail: Brenda.foreman@ct.gov or www.ct.gov/LTCOP

Michael Michalski, Regional Ombudsman
20 Meadow Road
Windsor, CT 06095
Intake: 860-723-1341
e-mail: Michael.michalski@ct.gov or www.ct.gov/LTCOP

Brenda Torres, LMSW, Regional Ombudsman
20 Meadow Road
Windsor, CT 06095
Intake: 860-424-5221
e-mail: Brenda.torres@ct.gov or www.ct.gov/LTCOP

Kimberly Massey, LCSW, Regional Ombudsman
1057 Broad Street
Bridgeport, CT 06604
Intake: 203-597-4181
e-mail: Kimberly.massey@ct.gov or www.ct.gov/LTCOP

Amber M. Burke, Regional Ombudsman
249 Thomaston Avenue
Waterbury, CT 06702
Intake: 203-597-4181
e-mail: amber.burke@ct.gov or www.ct.gov/LTCOP

Patricia Calderone, LMSW, Regional Ombudsman
249 Thomaston Avenue
Waterbury, CT 06702
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e-mail: patricia.calderone@ct.gov or www.ct.gov/LTCOP