Onondaga County Division of Mental Health Services

Request for Director of Community Services (DCS) Designee Status

APPLICATION FOR DESIGNEE STATUS FOR NY MHL §9.45 (10 §§ NYCRR 102.6[b], 102.7[a][2])

Name of Applicant: _____

Office Address: _____

Work Phone: _____

Cell Phone: _____

Email Address: _____

Licensure:

NYS Licensed Professional (Type of License)	License Number	Currently Active

Do you hold a Provisional or Limited – Permit status for your profession in NYS? **YES** **NO**

Education:

Education Completed	Discipline	Year Completed

Relevant Professional Work Experience:

Name of Employer, City, State - Position	Dates

Ethical/Legal Conditions:	Yes	No
Are you involved in any pending professional conduct proceedings in this state or any other state?		
Have you ever had any findings *(suspensions, restrictions, terminations, etc.)* of professional misconduct in this state or any other state?		
Have you been involved in any professional malpractice actions in this state or any other state?		
Have you had any judgments or settlements of professional malpractice actions in this state or any other state during the past ten years?		
Have you ever been suspended, sanctioned or otherwise restricted from participating in any private, federal or state health insurance program (e.g., Medicare, Medicaid)?		
In the past ten years, have any of the following ever been, or currently are in the process of being denied, revoked, suspended, modified, restricted, placed on probation, not renewed or voluntarily relinquished in this state or any other state?		
• Professional License		
• Other Professional Certification or License		
• Academic Appointment		
• Membership on any Professional Staff		
• Clinical Privileges at a Hospital or Health Care Facility		
• Professional Society Membership or Fellowship		

APPLICATION FOR DESIGNEE STATUS cont'd

Name of Applicant:

Ethical/Legal Conditions cont'd:	Yes	No
Have you voluntarily withdrawn an application for professional staff membership while under formal or informal investigation?		
Have you ever ceased or taken a voluntary leave of absence from the active practice of your profession?		
Have you ever been charged, indicted or convicted of a felony?		
Have you ever been charged, indicted or convicted of a misdemeanor?		

Physical/Mental Conditions	Yes	No
Are there any reasons for any inability to perform the essential functions of this position, even with reasonable accommodations?		
Do you have a mental health/substance and/or alcohol problem which might affect your current ability to perform as a designee?		
Have you ever been the subject of an indicated report to any State Child Abuse Registry?		

If you have answered "yes" to any question, please explain separately and include with this application. Answering "yes" to any one of the questions may not necessarily result in the rejection of your application.

Please note: Submission of an application does not grant designee status, which is subject to formal appointment by the Director of Community Services and requires completion of training and/or orientation.

I certify under penalty of perjury under the laws of the State of New York and the United States of America that the foregoing is true and correct.

Signed: _____ Dated: _____

ACCEPTANCE OF RESPONSIBILITY

Name of Applicant: _____

For §9.45 Designee Status Complete the Following:

As a Designee for the Director of Community Services of Onondaga County I understand and agree to the following:

- I have received a copy of, read and accept the responsibility as described in NYS Mental Hygiene Law (MHL) *§9.45*.
- *For New Applicants for Designee Only:* I will complete an initial training and participate in refresher trainings as provided by and prescribed by the Onondaga County Division of Mental Health Services regarding policies, procedures, and paperwork pertaining to Designee Status for the Director of Community Services (DCS).
- I will forward copies *(via fax or email)* to the Onondaga County Division of Mental Health Services immediately as is practicable, or within 24 hours of issuing a §9.45 on behalf of the DCS including: OMH Form 474A/476A and the Supporting Documentation Form to provide justification for the Order.
- This Designee status applies only to my role as an employee for the agency/program or facility stated in this application and is applicable only within the boundaries of Onondaga County.
- I agree to consult with Onondaga County Division of Mental Health Services regarding any questions I have pertaining to the validity or legitimacy of decisions made on behalf of the DCS.
- If any of the following are ever denied, revoked, suspended, modified, restricted, placed on probation, not renewed or voluntarily relinquished in the state of New York. Please notify the Director of Community Services within 48 hours.
    - Professional License
    - Other Professional Certification or Licensure
    - Academic Appointment
    - Membership on any professional staff
    - Clinical Privileges at a hospital or Health Care Facility
    - Professional Society Membership or Fellowship

_____ _____

Signature of Applicant Date

RECOMMENDATION – PERMISSION FROM EMPLOYEE ADMINISTRATION

Name of Applicant: _____

The applicant named above is requesting status as a Designee of the Director of Community Services (DCS) from Onondaga County Department of Children and Family Services Division of Mental Health Services. To consider this application, the employee must receive permission and/recommendation from the employing/sponsoring facility or agency.

Date of Staff Membership:

To the best of your knowledge, is there any reason why this practitioner should not be appointed as a Designee on behalf of the Onondaga County Director of Community Services? YES NO

If yes, please explain:

To the best of your knowledge, is the physical and mental health of this practitioner such as to permit him/her to practice without limitations? YES NO

If no, please explain:

If you are made aware that the following are ever denied, revoked, suspended, modified, restricted, placed on probation, not renewed or voluntarily relinquished in the State of New York for this applicant. Please notify the Deputy Commissioner Director of Community Services within 48 hours.

- Professional License
- Other Professional Certification or Licensure
- Academic Appointment
- Membership on any professional staff
- Clinical Privileges at a hospital or Health Care Facility.
- Professional Society Membership or Fellowship.

Please initial here to acknowledge that you have read and understand the above information: _____

Name of Person Completing this form Title

Signature Date

Agency Name:
Agency Address:
Contact Email:
Contact Phone:

RELEASE FROM LIABILITY

Name of Applicant: _____

I hereby release from liability all representatives of the Onondaga County Division of Mental Health Services, for their acts performed in good faith and without malice in connection with evaluating my application, credentials and qualifications and hereby release from any liability any and all individuals and organizations who provided information to the Onondaga County Division of Mental Health Services, in good faith and without malice, concerning my professional competence, ethics, character and other qualifications for eligibility and I hereby consent to the release and exchange of information relating to any disciplinary action, suspension, or curtailment of privileges to the Onondaga County Division of Mental Health Services.

All information submitted by me in this application is true to the best of my knowledge and belief. I fully understand that any misleading statement or material omission in this application may constitute cause for denial of eligibility and is a crime.

_____ _____

Signature of Applicant Date