**ACT Referral Checklist & Screening Tool**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
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|  |  |  |  |  | Referred to: |
| (Client Name) |  | (Referral Date) |  |  | Hennepin County Team |
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| Submission:  Referral Status: | | Please submit the completed referral form and all supporting documentation to the Designated ACT team via fax, secure email or interoffice mail.  For a referral to be complete the following information is required: | | | |
|  | | | | | |
|  | ACT Referral Checklist & Screening Tool (fully completed) | | | | |
|  | LOCUS within 30 days | | | | |
|  | Diagnostic Assessment (within one year) | | | | |
|  | Functional Assessment (including three deficit areas) within 30 days | | | | |
|  | Current and Historical Hospitalization Record / Dates | | | | |
|  | Civil Commitment / Prepetition paperwork (current / historical if allowed by release of information) | | | | |
|  | Supervisor signature (page 4) | | | | |
|  | | | | | |
| Referral Contact Information: | | | | | |
|  | | |  |  |  |
| Name of Individual Making the Referral | | |  | Phone # |  |
|  | | | | | |
|  | | |  |  |  |
| Supervisor Name | | |  | Supervisor Phone # |  |
|  | | | | | |
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**ACT Screening Tool**

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|  | | | | | |  | | | | |  | | | | |  | | | | | | |  | | | |  | |
| Referral Date: | | | | | |  | | | | | Referent Name: | | | | |  | | | | | | | Referent Phone #: | | | |  | |
|  | | | | | |  | | | | |  | | | | |  | | | | | | |  | | | |  | |
| Client Name: | | | | | |  | | | | | | | | | | | | | | | | | Phone Number: | | | |  | |
|  | | | | | |  | | | | |  | | | | |  | | | | | | |  | | | |  | |
| Address: | | | | | |  | | | | | | | | | | | | | | | | | Hospital: | | | |  | |
|  | | | | | |  | | | | |  | | | | |  | | | | | | |  | | | |  | |
| Birthdate: | | | | | |  | | | | | Social Security #: | | | | |  | | | | | | | MA #: | | | |  | |
|  | | | | | |  | | | | |  | | | | |  | | | | | | |  | | | |  | |
| **ICD 10 Diagnostic Code & Name**  **Code Name** | | | | | | | | | | | | | | | | | | **Diagnostic Assessment & LOCUS** | | | | | | | | | | |
|  | |  | | | | | | | | | | | | | | | |  | | | | | | | | | |  |
| 1. | |  | | | | |  | | | | | | | | | | | Date of last Diagnostic Assessment: | | | | | | | | | |  |
|  | |  | | | | | | | | | | | | | | | |  | | | | | | | | | |  |
| 2. | |  | | | | |  | | | | | | | | | | |  | | | | | | | | | | |
|  | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | |
| 3. | |  | | | | |  | | | | | | | | | | | LOCUS Score (within past 30 days): | | | | | | | | | |  |
|  | |  | | | | | | | | | | | | | | | |  | | | | | | | | | |  |
| 4. | |  | | | | |  | | | | | | | | | | |  | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |
| **Current Service Providers and Contact Information (Name / Agency / Phone)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Psychiatrist: | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Current psychiatrist approves ACT referral?  Yes,  No-If not, why: | | | | | | | | | | | | | | | | | | | |  | | | | | | | | |
| Is the client willing to switch to the ACT Team psychiatrist:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Medical Doctor: | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Therapist: | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Financial Worker: | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Representative Payee: | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Dentist: | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Other (specify; ARMHS, CADI, TCM, etc.): | | | | | | | | | | | | | | |  | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Civil Commitment Information** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Current Commitment Order: | | | | | | | | | | | | No (If no – skip this section & proceed to section ‘Health Plan Information’)  Yes (If yes - complete this section) | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Order Expiration Date: | | | | | | | | | | | |  | | | | | | | | |  | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Order Type: | | | | | | | | | | | | Commitment /  Stayed Order /  Other *(specify)*: | | | | | | | | | | | |  | | | |
|  |  | | | | | | | | | | | |  | | | | | | | | | | | |  | | | |
|  | Other Commitment Orders: | | | | | | | | | | | | Jarvis:  No,  Yes / Price-Sheppard:  No,  Yes | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Commitment Type: | | | | | | | | | | | | MI,  MI/CD,  CD,  MI&D,  Other *(specify)*: | | | | | | | | | | | |  | | | |
|  |  | | | | | | | | | | | |  | | | | | | | | | | | |  | | | |
|  | Commitment paperwork is attached: | | | | | | | | | | | | | Yes,  No-If no-why not: | | | | | | |  | | | | | | | |
|  |  | | | | | | | | | | | | | | | | | | | |  | | | | | | | |
| **Health Plan Information** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Medical Assistance: | | | | | | | | | Active /  Inactive /  Restricted / If PMAP-specify plan: | | | | | | | | | | | | | |  | | | | |
|  |  | | | | | | | | |  | | | | | | | | | | | | | |  | | | | |
|  | Other insurance: | | | | | | | | | No /  Yes- specify plan: | | | | | | |  | | | | | | | | | | | |
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| **Housing Information** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Current Living Situation:\* | | | | | | | | | | |  | | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | |  | | | | | | | | | | | | | | | | |
|  | \*Attach residential history if available | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | |  | | | | | | | | | | | | | | | | |
|  | Long Term Housing Plan: | | | | | | | | | | |  | | | | | | | | | | | | | | | | |
| **Other Information** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Current Medications:\* | | | | | | | | | | |  | | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | |  | | | | | | | | | | | | | | | | |
|  | \*Attach separate page as needed or if already another format. | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | |  | | | | | | | | | | | | | | | | |
|  | Current Income Sources: | | | | | | | | | | | SSI /  SSDI-RSDI /  MFIP /  Employment /  Other: | | | | | | | | | | | | | |  | | |
|  |  | | | | | | | | | | |  | | | | | | | | | | | | | |  | | |
|  | How often do you see the client?  more than once a week /  weekly /  monthly /  less than once a month | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | |  | | | | | | | | | | | | | | | | |
|  | How many hours per week / month? | | | | | | | | | | | | |  | | | | |  | | | | | | | | | |
|  |  | | | | | | | | | | |  | | | | | | | | | | | | | | | | |
| **Eligibility for Referral to ACT** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **The client** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | **Is 18+ years old** (Note: if 16-17 years old may be eligible but only upon approval by the MN DHS commissioner) | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | **Has a primary diagnosis of schizophrenia disorder, major depressive disorder with psychotic features, other psychotic disorder, or bipolar disorder.**  (Note: Primary diagnoses that are not eligible for ACT are substance use disorder, intellectual developmental disabilities, borderline personality disorder, antisocial personality disorder, traumatic brain injury, or an autism spectrum disorder.) | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | **Has functional impairments as demonstrated by at least ONE of the following (check all that apply):**  Significant difficulty consistently performing the range of routine tasks required for basic adult functioning in  the community or persistent difficulty performing daily living tasks without significant support or assistance;  Significant difficulty maintaining employment at a self-sustaining level or significant difficulty consistently  carrying out the head-of-household responsibilities;  Significant difficulty maintaining a safe living situation. | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | **Has need for continuous high-intensity services as evidenced by at least TWO of the following (check all):**  Two or more psychiatric hospitalizations or residential crisis stabilization services in the previous 12 months,  Frequent utilization of mental health crisis services in the previous six months,  30 or more consecutive days of psychiatric hospitalization in the previous 24 months,  Intractable, persistent, or prolonged severe psychiatric symptoms,  Coexisting mental health and substance use disorders lasting at least six months,  Recent history of involvement with the criminal justice system or demonstrated risk of future involvement,  Significant difficulty meeting basic survival needs,  Residing in substandard housing, experiencing homelessness, or facing imminent risk of homelessness,  Significant impairment with social and interpersonal functioning such that basic needs are in jeopardy,  Coexisting mental health and physical health disorders lasting at least six months,  Residing in an inpatient or supervised community residence but clinically assessed to be able to live in a more  independent living situation if intensive services are provided,  Requiring a residential placement if more intensive services are not available,  Difficulty using traditional office-based outpatient services effectively.  Please provide a detailed explanation of any areas marked above | | | | | | | | | | | | | | | | | | | | | | | | | |

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| **Additional Criteria** | | |
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|  | There are no indications that other available community-based services would be equally or more effective as evidenced by consistent and extensive efforts to treat the individual. | |
|  | In the **written** opinion of a licensed mental health professional, the client has the need for mental health services that **cannot** be met with other available community-based services, or is likely to experience a mental health crisis or require a more restrictive setting if assertive community treatment (ACT) **is not provided**. | |
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| **Priority will be given to individuals who meet at least one of the following criteria** (Check all that apply, please provide records) | | | | |
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|  | The person has been or will be recently discharged from an extended stay in a state hospital. | | | |
|  | Name of facility: |  | Length of stay: |  |
|  | High utilization of acute psychiatric hospitals.  Specify the approximate # of admissions over the past two years:       Total bed days: | | | |
|  | High utilization of psychiatric emergency services.  Specify Type & approximate number of admissions:  ED#:     /  Crisis #:     /  Detox #: | | | |
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| **Language, Cultural & Other Considerations** | |
| What is the client’s primary language? |  |
|  |  |
| Pertinent cultural information: |  |
|  |  |
| Any other significant client information: |  |

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Referent Supervisor’s Signature Date

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **To Be Completed By ACT Team Leader** | | | | | |
|  | Client will be opened with ACT Team, services are medically necessary. | | | | |
|  |  | | | | |
|  | Client will not be opened with ACT services. Reason: |  | | |  |
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|  | Recommendations for alternative services to ACT Team: |  | | |  |
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|  | | |  | | |
|  | Mental Health Professional’s Name/Signature | |  | Date |  |
|  | | | | | |