**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:  |       |
|  |  |  |  |
| **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

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| **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  |  |
|  |