ACT Referral Checklist & Screening Tool

(Client Name) (Referral Date)

Referred to:

- [ ] Hennepin County Team

Submission: Please submit the completed referral form and all supporting documentation to the Designated ACT team via fax, secure email or interoffice mail.

Referral Status: 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 #

ACT Screening Tool

Referral Date: ____________ Referent Name: ______________________ Referent Phone #: ______________

Client Name: ____ Phone Number: ______________

Address: ____ Hospital: ______________

Birthdate: ____________ Social Security #: ______________________ MA #: ______________

ICD 10 Diagnostic Code & Name

	Code	Name
1.		
2.		
3.		
4.		

Diagnostic Assessment & LOCUS

Date of last Diagnostic Assessment: ______________

LOCUS Score (within past 30 days): ______________

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:

R·E·H
ReEntry House

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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ReEntry House

Additional Criteria

- ☐ 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**.

Priority will be given to individuals who meet at least one of the following criteria (Check all that apply, please provide records)

- ☐ 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 #: ___

Language, Cultural & Other Considerations

What is the client's primary language? ______________________

Pertinent cultural information: ______________________

Any other significant client information:

______________________ ______________
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