

ACT Referral Checklist & Screening Tool

_____	_____	Referred to:
(Client Name)	(Referral Date)	<input type="checkbox"/> Hennepin County Team
		<input type="checkbox"/> Ramsey County Teams
		<input type="checkbox"/> Anoka 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	Diagnostic Assessment & LOCUS
Code	Name
1. _____	Date of last Diagnostic Assessment: _____
2. _____	
3. _____	
4. _____	
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: _____

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

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: _____

- Recommendations for alternative services to ACT Team: _____

Mental Health Professional's Name/Signature

Date