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HEALTH
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ACT Referral Form & Screening Tool

Date of Referral:

Name:	*Phone:*	Referred To:
Date of Birth: *(must be 18+ to be eligible)*	*Social Security #:*	☐ Hennepin County Team ☐ Ramsey County Teams ☐ Anoka County Team ☐ Washington County Team ☐ Ramsey Forensic ACT *(requires probation or supervised release in RC)*
Primary Language/Interpreter needs:		
Home Address: *Current location if other than home:*		

Individuals typically need to be open with Medicaid (straight MA or PMAP) to be enrolled in ACT. Please note any known barriers or delays to active enrollment. ***MA Number***
If PMAP, note Health Plan: ***Other insurance information:***

Referring Party Name / Agency:
Email: Phone:
For TCM Providers: Supervisors Name Email: Phone:

ACT requires one of the following diagnoses. Please check which is applicable to the referred individual:

- ☐ Major Depression with psychotic features
- ☐ Schizophrenia
- ☐ Schizoaffective Disorder
- ☐ Bipolar Disorder

Other noted diagnoses:

ACT cannot serve people who have one of the following primary diagnoses. DO NOT REFER Unless the presence of the behaviors or functional limitations experienced by the person are correlated to primary psychotic disorder.

Please check any applicable diagnoses:

- ☐ Borderline Personality Disorder
- ☐ Anti-social Personality Disorder
- ☐ Substance Use Disorder
- ☐ Traumatic Brian Injury
- ☐ Borderline IQ

Current Providers (Name / Agency / Phone) and Relevant Information:

Psychiatrist: _____

Current psychiatrist approves ACT referral? ☐ Yes, ☐ No-If not, why: _____

Is the client willing to switch to the ACT Team psychiatrist: ☐ Yes ☐ No (If not, cannot be admitted to ACT)

Other providers: Therapy, ARMHS, CADI, TCM, etc.): _____

Supervising Probation Agent: **Name** Email: Phone:

Current sources of income: ☐ SSI / ☐ SSDI-RSDI / ☐ MFIP / ☐ Employment / ☐ Other:
Current medication (attach lists as needed):

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Civil Commitment Information *(Skip this section if no current commitment order)*
Commitment Type: ☐ MI, ☐ MI/CD, ☐ CD, ☐ MI&D, ☐ Other *(specify)*:
Order Expiration Date:
Other orders: Jarvis: ☐ No, ☐ Yes / Price-Sheppard: ☐ No, ☐ Yes / Other:

Eligibility Screen: ***In addition to diagnostic criteria, clinical need must be present. Please check all that apply:***

☐ **Has functional impairments as demonstrated by at least ONE of the following:**

- ☐ 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:**

- ☐ 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.

Priority will be given to individuals who meet <u>at least one</u> of the following criteria

☐ The person has been or will be recently discharged from an extended stay in a state hospital or correctional facility.
Name of facility: _____ Length of stay: _____

☐ High utilization of psychiatric hospitals or emergency psychiatric services. Specify approximate # of admissions over the past two years: ☐ Inpatient #/days: ___ / ___ / ☐ ED#: ___ / ☐ Crisis #: ___ / ☐ Detox #: ___

If available, include the following records. If not available, we may need to work with you and the individual to get records before making an eligibility determination.

☐ Diagnostic Assessment (within one year)	☐ Current and Historical Hospitalization Records / Dates	☐ Civil Commitment / Prepetition paperwork (current / historical)
☐ Functional Assessment	☐ LOCUS	☐ MH professional - statement of need

Please either fax or send referrals via secure email to the team you are referring to. You will be contacted within 24 business hours to determine next steps. We are happy to consult prior to referral.

Anoka County	Phone: 763-201-8060	Fax: 763-712-5588	anokaactreferrals@radiashealth.org
Hennepin County	Phone: 612-435-7207	Fax: 612-435-7201	henactreferrals@radiashealth.org
Ramsey Co. Blue Team(non-FACT)	Phone: 651-389-4628	Fax: 651-389-4691	ramactreferrals@radiashealth.org
Ramsey Co. Purple Team(non-FACT)	Phone: 651-389-4629	Fax: 651-389-4691	ramactreferrals@radiashealth.org
Ramsey County - FACT	Phone: 651-783-5480	Fax: 651-783-5479	factresearch@radiashealth.org
Washington County	Phone: 651-783-5410	Fax: 651-783-5411	washactintake@radiashealth.org