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ReEntry House

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 # _____

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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:

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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

☐ 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