YORK/ADAMS REFERRAL FOR
ASSERTIVE COMMUNITY TREATMENT (ACT)
Fax to **Community Care Behavioral Health (1-866-418-0366)**

Demographic, Identifying and Contact Information:

(All the following information is required to activate a referral) Referral Date _____

Client Name: _____ DOB: _____

MA ID# : _____ SS#: _____

Current Address: _____

Current Phone #'s: _____

Case Manager's Name: _____ Phone #: _____

Who is making the referral? _____ Phone #: _____

Referral discussed with consumer? _____

Response: _____

Primary Language Spoken: _____

Release of Information signed for referral to York/Adams HCMU, Community Care Behavioral Health, and to Bell Socialization Services ACT Team, if approved. Yes No

Consumer Eligibility:
Adults, age 18 years of age or older, who have serious and persistent mental illness. A person shall be considered to have a serious and persistent mental illness when all of the following criteria for diagnosis, treatment history, and functioning level (A, B, and C) are met.

A. Diagnosis: Primary diagnosis of schizophrenia or other psychotic disorders such as schizoaffective disorder, or bipolar disorder as defined in the DSM 5 (or subsequent update). Individuals with a primary diagnosis of a substance use disorder, intellectual developmental disability, or brain injury are not the intended consumer group.

List Current Diagnosis

Behavioral Health: _____

_____

_____

Medical Conditions/Physical Health issues: _____

_____

_____

Current:

Medications	Dose	Frequency

Attach additional sheet if needed.

B. Consumer who meets at least two (2) of the following criteria:

a. As of the referral date, at least <u>two</u> (2) psychiatric hospitalizations in the past 12 months or lengths of stay totaling over 30 days in the past 12 months that can include admissions to the psychiatric emergency services.

Facility/Hospital	Dates	Outcome/Disposition

b. Intractable (i.e., persistent or very recurrent) severe major symptoms (e.g., affective, psychotic, suicidal):

<u>List Life Threatening/Self Harm Behaviors:</u>

Method	Date	Disposition

Describe severe major symptoms:

_____

_____

_____

c. List co-occurring mental illness and substance use disorders with more than six months duration at the time of contact.

List Substances Abused/Dependent/Treatment History, if known.

Type	Frequency	Date Last Used

d. High risk or recent history of criminal justice involvement which may include frequent contact with law enforcement personnel, incarcerations, parole or probation:

List Incarcerations/Criminal Justice System Involvement in the past 12 months:

Incarceration/Law Enforcement	Date of Encounter	Outcome/Disposition

Probation/Parole; Name of Officer; Length of Service; Reason:

_____

_____

e. Literally homeless, imminent risk of being homeless, or residing in unsafe housing. Describe in detail: _____

_____

_____

f. 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, or requiring a residential or institutional placement if more intensive services are not available. Explain: _____

C. Difficulty effectively utilizing traditional case management or office-based outpatient services, or evidence that individual requires a more assertive and frequent non-office based service to meet individual's clinical needs.

List the current services the consumer is involved with including case management:

Type of Service	# of Contacts/Weeks	Date Last Used	Outcome

ADDITIONAL INFORMATION REQUESTED:

Indicators of Consumer's Strengths and Supports

A. Identify consumer's support system, including family, friends, social community, etc.

List Supports and Relationship	Frequency of Contact

B. Identify Member Strengths:

Educational/Vocational History. List Educational and Vocational History

Medical Conditions and Activities of Daily Living:

Medical Conditions

Activities of Daily Living: Check all that apply:

____ Visually Impaired ____ Hearing Impaired ____ Language Barrier

____ Independent with ADL's

____ ADL Dependent: Explain: _____

_____

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Outcome of Community Care / York/Adams HealthChoices Review

Referral received on: _____

Review Date: _____

Outcome:

____ Not approved Referral Source Notified on: _____

____ Approved for Referral to York/Adams Adult ACT

Initial Authorization given for _____ units from _____ to _____.