HealthPort

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Assertive Community Treatment (ACT)

Serving: Somerset, Worcester, Wicomico, Dorchester, Talbot, Caroline Counties

Checklist for Individuals who meet basic criteria for ACT

ACT is designed for adults with severe mental illness who are most at-risk of psychiatric crisis and hospitalization and involvement in the criminal justice system. ACT is a multidisciplinary team approach with assertive outreach in the community and are available to the consumer on a 24/7 basis.

Admission Criteria:

Criteria from categories 1-3 are necessary for admission:

1. **The consumer has a PMHS specialty mental health diagnosis included in the Priority Population List, which is the cause of significant psychological, personal care, and social impairment. Please include all that apply:**

	Code	Diagnosis		Code	Diagnosis
☐	F20.9	Schizophrenia	☐	F31.13	BP1 Disorder, MRE Manic, Severe
☐	F20.81	Schizophreniform Disorder	☐	F31.2	BP1 Disorder, MRE Manic, w/Psychotic Features
☐	F25.0	Schizoaffective Disorder, BP Type	☐	F31.4	BP1 Disorder, MRE Depressed, Severe
☐	F25.1	Schizoaffective Disorder, Depressed	☐	F31.5	BP I Disorder, MRE Depressed, w/ Psychotic
☐	F28	Other Specified Schizophrenia Spectrum	☐	F31.0	BP 1 Disorder, MRE Hypomanic
☐	F29	Unspecified Schizophrenia Spectrum	☐	F31.9	BP 1 Disorder Unspecified
☐	F22	Delusional Disorder	☐	F31.81	BP II Disorder
☐	F33.2	MDD, MRE Severe	☐	F60.3	Borderline Personality Disorder
☐	F33.3	MDD, MRE Severe, with psychotic	☐	F21	Schizotypal Personality Disorder

2. **The impairment results in at least one of the following:**
   - ☐ A clear, current threat to the Individual's ability to live in his/her customary setting, or the Individual is homeless, and would meet the criteria for a higher level of care if mobile treatment services were not provided. The individual is homeless.
   - ☐ An emerging/impending risk to self or others.
   - ☐ Inability to engage in traditional outpatient treatment.

3. **Inability to form a therapeutic relationship on an ongoing basis as evidenced by at least one of the following:**
   - ☐ Frequent use of emergency rooms for psychiatric reasons.
   - ☐ Psychiatric hospitalizations
   - ☐ Arrest for reasons associated with the Individual’s mental illness.

Referral Process

1. Within 10 working days of receiving a complete referral, the Assertive Community Treatment Team will arrange for staff to visit applicant to conduct a face to face screening assessment to determine needs, strengths, available resources, and willingness to participate in the Assertive Community Treatment Services offered.
2. Within 5 working days of the screening assessment, the individual and the referral source will be notified whether the Assertive Community Treatment Team:
   a. Accepts the individual and will begin enrollment process
   b. Will accept the individual, following an updated review of the individual's eligibility, when when program capacity permits.
   c. Denies services due to ineligibility.
   d. Will accept the individual, following an updated review of the individual's eligibility, after the individual's discharge or release from an inpatient facility or detention center.

Release and Authorization

I, ____, authorize the release/exchange of all available information between the following agencies/individuals to support my application to HealthPort. If services are terminated or denied, I authorize the release of information pertaining to the denial or termination, including the reason for these actions, effective date, and, when appropriate, discharge plans.

This Release/Authorization Form is effective for 90 days

Emergency Contact: _____________________________________ Phone Number: _______________________

Address: ____ Relationship: _________________________

Mental Health Provider: _________________________________ Phone Number: _______________________

Somatic Provider: _______________________________________ Phone Number: _______________________

Referring Agency: _______________________________________ Phone Number: _______________________

Referring Individual: _____________________________________ Phone Number: _______________________

I understand that application for Assertive Community Treatment Services is being made on my behalf and agree to this referral for services.

Signed: ____ Date: _________________________

Witness: ____ Date: _________________________

Referral Form

Client Name: ____ Date of Referral: ________________

Date of Birth: _________________________________ Social Security Number: ________________________

Sex: ☐ Male ☐ Female Gender Identity: ________________ Currently Inpatient: ☐ Yes ☐ No

Current Living Arrangement: (If inpatient, living arrangement prior to hospitalization)

☐ Lives Alone ☐ Lives with family/friend ☐ Homeless ☐ RRP ☐ Other ______________________

Address: ____

Mobile Phone: ______________________________ Home Phone: _________________________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed # Children ___________________

Ethnic Group: ☐ African American ☐ Hispanic ☐ White Non-Hispanic ☐ Asian/Pacific Island

☐ American Indian/Alaska Native ☐ Other ______________________________

Current Entitlement Information

☐ Social Security Amount ________________ ☐ PAA Amount ________________

☐ SSI Amount ________________ ☐ VA Benefits Amount ________________

☐ SSDI Amount ________________ ☐ Salary/Wages Amount ________________

☐ Other Income: Type: ______________________________ Amount: ____________________

☐ Medicaid ID Number _____________________ ☐ Medicare ID Number ____________________

Current ICD 10 Diagnoses

Behavioral Diagnoses: ____

Primary Medical Diagnoses: ____

Social Elements Impacting Diagnosis: ☐ Financial ☐ Social Environment ☐ Occupational ☐ Legal

☐ Primary Support Group ☐ Housing ☐ Homelessness ☐ Access to Healthcare

Currently Medication Compliant: ☐ Yes ☐ No ☐ With Reminders

Medications Currently Prescribed, if known, as well as who prescribed. You may attach a separate sheet:

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Currently Compliant with Outpatient Mental Health Appointments ☐ Yes ☐ No

Barriers to Outpatient Treatment ____

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Presenting Problems: (Check all that apply and provide elaboration)

☐ Visual or Hearing Impairment: Explain ______________________________

☐ Physical Disability: Explain ______________________________

☐ Chronic Health Problems/Somatic Issues ______________________________

☐ Special Dietary Needs ______________________________

☐ Drug or Alcohol Abuse Explain: ______________________________

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☐ Social/Interpersonal Conflicts, Including Marital and Family Problems ______________________________

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☐ Hallucinations/Delusions ______________________________

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☐ Depression/ Mood Disorder ______________________________

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☐ Suicide Threat/Attempts/Self Harm, Include date of most recent occurrence ______________________________

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☐ Homicidal Threat/Attempt ______________________________

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☐ Violent/Assaultive Behavior ______________________________

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☐ Other: Include specific detail ______________________________

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Access to Weapons: ☐ Yes ☐ No ☐ Unknown If yes, please list ______________________________

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Level of Functioning: Able to Read ☐ Yes ☐ No Able to Write ☐ Yes ☐ No

Highest grade completed, if known ____________________ Special Education ☐ Yes ☐ No

Psychiatric Hospitalization History **Number of Hospitalizations (Lifetime)** ______________

3 Most Recent Hospitalizations

Institution ______________________________ Date ______________

Institution ______________________________ Date ______________

Institution ______________________________ Date ______________

Reasons for hospitalizations ______________________________

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Forensic Status ☐ No Forensic Status ☐ Conditional Release ☐ Parole/Probation ☐ Not Criminally Responsible

Conditions of Probation/Parole/ Pending Charges ____

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Probation/Parole Contact Information ____

Treatment History: Has the individual been referred to or participated in any of the following? If yes, where and when?

☐ Outpatient Addictions Treatment ____

☐ Inpatient Addictions Treatment ____

☐ Dual Diagnosis Treatment ____

☐ Outpatient Mental Health Treatment ____

☐ Psychiatric Rehabilitation Program, Including Residential Rehabilitation/Supervised Housing ____________________

____

☐ Supported Employment ____

☐ Targeted Case Management ____

Social History

Employment History: Include all past jobs and reasons for leaving them, also include volunteer positions:

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____

Family History Include information about support system, family history of mental illness, siblings, family structure, and significant others as well as living situation ____

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Community Include agency contacts, court involvement, church, social groups, support system

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Reason for Referral: Include risks to self and others, risk for hospitalization or incarceration, difficulty with outpatient treatment engagement, Emergency Room Use, Hospitalization History, all other helpful information

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