COMMUNITY CARE
Behavioral Health Organization

Form Instructions

1. The referral source will complete this form for any new referral to CTT/ACT or any person transitioning between CTT/ACT Teams. **All sections of this document must be thoroughly completed and legible in order to make a determination of services. Items should not be left blank- please indicate N/A where appropriate.** A psychiatric evaluation completed within the past year and faxed along with the referral is preferred and may be requested as part of the review.

2. The signature of the person being referred is required indicating that they understand that a referral is being made and that CTT/ACT is an all inclusive service. The signature must be no more than 30 days from the date of the referral. If the person is unable to sign, the referral source must state if it is due to current symptoms, physical limitations, or other. Include the name and phone number of the person who discussed the CTT/ACT referral with the individual being referred.

3. Please send the completed form via secure email or fax to the appropriate contract.

After Form Submission

1. HealthChoices member referrals will be reviewed by Community Care for Medical Necessity Guidelines.

2. Community Care will follow up with the referral source to review the CTT/ACT referral and request additional information if needed.

3. If the individual being referred does not meet Medical Necessity Guidelines for CTT/ACT, recommendations will be made for an alternative and appropriate level of support and treatment necessary to address the needs of the person being referred.

4. If the individual being referred meets Medical Necessity Guidelines for CTT/ACT, Community Care will forward the referral form to the CTT/ACT provider and confirm the date that the team plans to make initial contact with the individual. This date and the team assigned will be relayed by Community Care to the referral source.

5. The referral source is required to assist with linking the CTT/ACT Team with the individual to help with engagement. A transition meeting is also required with all involved treatment providers, the person referred, and supports in order to share relevant treatment history and to plan for transition. Transition from current services to CTT/ACT should be well coordinated and can span up to 90 days in order to allow for team engagement and assessment.

6. Once CTT/ACT is approved and a provider is assigned, the referral source will obtain a signed Release of Information and fax clinical records (including the most recent psychiatric eval and list of medications) directly to the assigned CTT/ACT provider. Records should be faxed within 5 days of CTT/ACT assignment.

7. The CTT/ACT provider can request an assignment to another level of care within 30 days of the initial assignment if upon full assessment the Medical Necessity Guidelines are not met. If this request is made, the CTT/ACT provider will relay the clinical rationale to Community Care. Additional clinical information may be requested.

Demographic, Identifying, and Contact Information

Name: (First) _____ (Last) _____

Chosen Name: _____ Pronouns: _____

MA ID#: | | | | | | | | | | | DOB: *(mm/dd/yyyy)* _____

Current Address: _____

Current Phone #'s: *(do not include dashes)* (Main) _____ (Other) _____

Guardian Name: _____ Guardian Phone #: *(do not include dashes)* _____

Current Community Provider Contact(s) Name(s) and Phone #s *(do not include dashes)*:

Psychiatrist: _____ Agency: _____ Phone #: _____

SC/BCM: _____ Agency: _____ Phone #: _____

Therapist: _____ Agency: _____ Phone #: _____

PCP: _____ Phone #: _____

Rep Payee: _____ Phone #: _____

Other: _____ Agency: _____ Phone #: _____

Additional Information:

Include information regarding the clinical rationale for requesting CTT/ACT. If CTT/ACT is being requested as a result of a meeting, provide information regarding the type of meeting that occurred, where the meeting occurred, and the date of the meeting. Examples: Disposition meeting, Single Point of Accountability (SPA) meeting, Clinical Case Consultation, Multidisciplinary Treatment Team meeting.

CTT/ACT has been explained as an all inclusive service and if CTT/ACT is approved I understand that I will have to transition from my current treatment providers. I understand and am in agreement with the CTT/ACT referral.

Signature of Person Referred _____ Date: *(mm/dd/yyyy)* _____

If no signature obtained, reason why: _____

Name of person who completed referral/ explained CTT/ACT services being referred: _____ Phone: _____ *(do not include dashes)*

All sections of this document must be thoroughly completed. Items should not be left blank - please indicate N/A where appropriate. A Psychiatric Evaluation that has been completed within the past year is preferred and may be requested as part of the review.

Admission Criteria

Must Meet Criteria I AND II OR III (exclusion criteria)

I. Diagnosis

The individual must have a primary diagnosis of Schizophrenia or other Psychotic Disorder or Chronic Major Mood disorder. Individuals with a primary diagnosis of a Substance Use Disorder, Intellectual Developmental Disability, Personality Disorder, Autism Spectrum Disorder, or Brain Injury are not the intended member group. Please list all diagnoses.

Behavioral Health _____

Behavioral Health _____

Behavioral Health _____

Medical Conditions/
Physical Health Issues _____

Medical Conditions/
Physical Health Issues _____

Medical Conditions/
Physical Health Issues _____

List of All Current Medications and Dose:

Medication: _____ Dose: _____ Frequency: _____

Side Effects/Comments: _____

Medication: _____ Dose: _____ Frequency: _____

Side Effects/Comments: _____

Medication: _____ Dose: _____ Frequency: _____

Side Effects/Comments: _____

Medication: _____ Dose: _____ Frequency: _____

Side Effects/Comments: _____

Medication: _____ Dose: _____ Frequency: _____

Side Effects/Comments: _____

Medication: _____ Dose: _____ Frequency: _____

Side Effects/Comments: _____

Medication: _____ Dose: _____ Frequency: _____

Side Effects/Comments: _____

II. Indicators of Continuous High Service Needs

Must have A or B: (check the indicator and complete supporting clinical evidence)

A. ☐ Two or more psychiatric hospitalizations in the past year

OR

☐ Discharge from a state hospital or extended acute unit/extended care unit within the past year.

OR

☐ Five face to face encounters with emergency services personnel (psychiatric, arrest, other services) within the past year.

List hospitalizations, incarcerations, emergency encounters, delinquency of juvenile justice, and expulsion and suspension in the last 12 months. List in **most recent** order.

	Type/Facility	Admission Date *(mm/dd/yyyy)*	Discharge Date *(mm/dd/yyyy)*
1.			
2.			
3.			
4.			
5.			

B. ☐ Inability to participate in OR remain engaged OR respond to traditional community based services. *(Evidence exists of documented efforts to engage the person by a licensed treatment or service coordinator provider for 45 days and supporting documentation that without Behavioral Health (BH) treatment and support, the person's well-being and stability will be jeopardized).*

	List Services in the Last Five (5) Years: Type of Service Used	# of contacts/week	Date of last contact *(mm/dd/yyyy)*
1.			
2.			
3.			
4.			
5.			

II. Indicators of Continuous High Service Needs

Must have three (3) of the following:
Check the applicable indicator and complete supporting clinical evidence

C. ☐ There is evidence of current, coexisting Mental Illness and Substance Use Disorder.

	List Substances Used/Dependent: Type	Frequency	Date of last use *(mm/dd/yyyy)*
1.			
2.			
3.			
4.			
5.			

D. ☐ History of life threatening suicide attempts/life threatening self-harm.

	List Specific Behaviors/Method	Outcome (admitted to, etc)	Date *(mm/dd/yyyy)*
1.			
2.			
3.			
4.			
5.			

E. ☐ History of impulsive acting out, physical assault, or uncontrolled anger that resulted in physical harm or real potential harm to others (ex. assault, rape, arson). Include current or history of legal charges.

	List Impulsive/Acting Out Behavior	Outcome (arrest, etc)	Date *(mm/dd/yyyy)*
1.			
2.			
3.			
4.			
5.			

II. Indicators of Continuous High Service Needs

F. ☐ Lack of support system. List current natural support system (family, friends, social programs) and frequency of contact. If there were natural supports who are no longer involved, provide a brief reason why no longer involved.

	List Supports/Relationships	Frequency of Contact/Last Contact	Reason No Contact
1.			
2.			
3.			
4.			
5.			

G. ☐ History of inadequate follow through with elements of a Treatment Plan that result in psychiatric or medical instability (including lack of follow through taking medication, following a crisis plan, attending to health needs, or maintaining housing.)

	List Behaviors Indicating Lack of Follow Through	What Happens
1.		
2.		
3.		
4.		
5.		

H. ☐ Identify psychotic or mood related symptoms person experiences when symptomatic that interfere with daily functioning.

1. _____
2. _____
3. _____
4. _____
5. _____

I. ☐ Threats of physical harm to others with or without follow through behaviors within the past two (2) years:

1. _____
2. _____
3. _____
4. _____
5. _____

II. Indicators of Continuous High Service Needs

J. ☐ Current homelessness resulting in the person living on the street, in a shelter, or substandard housing
OR
The individual is currently receiving treatment in an inpatient psychiatric hospital, or is maxed out on time served, or is living in a supervised community residence but is clinically assessed to be able to live in more independent living if intensive services are provided, or to prevent admission to a more intensive level of care.

List in order all recent housing placements: Type of Residence	Dates *(mm/dd/yyyy)*
1.	
2.	
3.	
4.	
5.	

III. Exception

☐ Check if met

The individual does not meet medical necessity guidelines I and II but is designated as appropriate to receive CTT/ACT by a multidisciplinary team which includes representatives of Community Care in consultation with a Professional Advisor, as well as Health Choices, and/or County MH office.

Include contact info as follows:

County MH Office/Health Choices Participant: _____ Phone #: *(no dashes)* ☐

Tobacco Cessation

Tobacco screen completed on: *(mm/dd/yyyy)* ☐

Tobacco user? ◯ Yes ◯ No

Has cessation been discussed? ◯ Yes ◯ No

Is member interested in a referral for smoking cessation?

◯ Yes ◯ No

☐ Referred to Tobacco Cessation Therapist/Program

☐ Referred to Quit Line

To be completed by Community Care

Accepted/Approved for CTT/ACT Assignment ( ):

Assigned CTT/ACT Team _____

MCO Reviewer _____ Date: *(mm/dd/yyyy)* _____