St Luke's Penn Foundation

MENTAL HEALTH SERVICES

Assertive Community Treatment Team Referral Form
Bucks and Montgomery Counties

Form Instructions:

1. The referral source will complete this form for any new referral to St. Luke's Penn Foundation ACT/FACT teams. All sections of this document must be completed and legible to help us make a determination regarding services. Items should not be left blank- please indicate N/A where appropriate. A psychiatric evaluation completed in the past year and returned 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 ACT is an all-inclusive service. The signature must be no more than 30-days from the date of 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 ACT referral with the individual being referred.

3. Please send the completed form to Deborah Strouse, ACT/FACT Manager, via secure e-mail to Deborah.Strouse@sluhn.org.

4. Please call Deborah Strouse at (267) 404-5025 for any questions or concerns regarding the referral process.

After Form Submission:

1. All referrals will be reviewed for Medical Necessity Guidelines.

2. The Manager ACT/FACT Services or their designee will follow up with the referral source to review the ACT referral and request additional information if needed.

3. If the individual being referred does not meet Medical Necessity Guidelines for 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 ACT, the referral will be forwarded to the appropriate ACT Team Leader who will confirm the date that the team plans to make initial contact with the individual. This date and the team assigned will be relayed to the referral source.

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

6. The referral source will obtain a signed Release of Information and fax clinical records (including the most recent psychiatric evaluation and complete list of medications) to the assigned ACT team. Records should be faxed within 5 days of ACT assignment.

7. The ACT team 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 ACT team will relay the clinical rationale to Magellan Behavioral Health and the County of residence. Additional clinical information may be requested.

EXCLUSION CRITERIA- Individuals with the following are not appropriate for ACT/FACT services:

1. The individual refuses this level of support. ACT/FACT services are voluntary.
2. The individual has an incarceration with a remaining sentence of 6 months or more.
3. The individual is acutely at risk of harm to self or others that requires a more intensive level of support beyond community-based interventions.
4. The individual has 6 months or more of stipulated legal treatment in a higher level of care (e.g., PHP, EAC, etc.).
5. The individual is diagnosed with an Intellectual Disability.
6. The individual is diagnosed on the Autism Spectrum.
7. The individual is diagnosed with a Traumatic Brain Injury.

NB: Any exception to these exclusions must be approved by Magellan Behavioral Health AND the County Office.

Demographic, Identifying, and Contact Information

First Name: Last Name:

Preferred Name: Preferred Pronouns:

MA ID# Date of Birth

Current Address:

City: State: Zip Code:

County: Social Security Number:

Preferred Phone Number Secondary Phone Number

Guardian Name: Phone Number

NB: Any referrals for clients with LEGAL GUARDIANS must be accompanied by the active court order that defines the type of guardianship. Referrals for clients with legal guardians must be signed by both the client and the legal guardian. The legal guardian must be willing and able to sign all documentation throughout treatment, including treatment plans, crisis plans, and all consents for treatment-related concerns.

Current Community Provider Contact(s) Name(s) and Phone #s:

Psychiatrist: Agency:

Phone Number

Case Manager: Agency:

Phone Number

Therapist: Agency:

Phone Number

PCP: Phone Number

Probation Officer/ Office Phone Number

Monthly Income: Income Source:

Rep Payee: Phone Number

Are you making any other referrals for this individual? If so, please provide details:

Additional Information:
Include information regarding the clinical rationale for requesting ACT/FACT services. If ACT/FACT 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.

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

Signature of Person Referred: Date

If no signature obtained, reason why:

Name of person who completed referral Phone Number

Name of person who explained ACT services: Phone Number

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)

1. 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:

Physical Health:

Physical Health:

Physical Health

List of all Current Medications and Dosages:

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:

ALLERGIES:

2. Indicators of Continuous High Service Needs

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

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

OR

☐ One inpatient psychiatric hospitalization with a length of stay which exceeds 30 days.

OR

☐ One criminal incarceration of 30 days or more.

OR

☐ Two or more completed criminal incarcerations in the last 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 within the last 12 months. List in **most recent** order.

Type/ Facility		Admission Date		Discharge Date	
Type/ Facility		Admission Date		Discharge Date	
Type/ Facility		Admission Date		Discharge Date	
Type/ Facility		Admission Date		Discharge Date	
Type/ Facility		Admission Date		Discharge Date	

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 treatment and support, the person's well-being and stability will be jeopardized).

List Services in the Last Five Years:

Type of Service:		# of contacts/week		Date of last contact:	
Type of Service:		# of contacts/week		Date of last contact:	
Type of Service:		# of contacts/week		Date of last contact:	
Type of Service:		# of contacts/week		Date of last contact:	
Type of Service:		# of contacts/week		Date of last contact:	

Additional information regarding treatment episodes:

2. Indicators of Continuous High Service Needs (continued)

Must have three 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:

Type:		Frequency:		Date of last use:	
Type:		Frequency:		Date of last use:	
Type:		Frequency:		Date of last use:	
Type:		Frequency:		Date of last use:	
Type:		Frequency:		Date of last use:	

D. ☐ History of life-threatening suicide attempts/life threatening self-harm within the past two years.

List Specific Behaviors/Methods	Outcome (admitted to, etc.)		
		Date:	
		Date:	
		Date:	
		Date:	
		Date:	

E. ☐ History of impulsive acting out, physical assault, or uncontrolled anger that resulted in physical harm or real potential harm to others (e.g., assault, rape, arson) within the past two years. Include all current or pertinent history of legal charges.

List Specific Behaviors/Methods	Outcome (arrest, etc.)		
		Date:	
		Date:	
		Date:	
		Date:	
		Date:	

Have there been any incidents of fire-setting? Please explain	

2. Indicators of Continuous High Service Needs (continued)

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

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?

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

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

J. Current homelessness resulting in the person living on the street, in a shelter, or in 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

	Date:	
	Date:	
	Date:	
	Date:	
	Date:	

3. Exception

☐ Check if met.

The individual does not meet medical necessity guidelines 1 and 2 but is designated as appropriate to receive ACT/FACT by a multidisciplinary team which includes representatives of Magellan Behavioral Health in consultation with a Professional Advisor, as well as Health Choices, and/or the County MH office.

Include contact info as follows:

County MH Office Representative:		Phone Number	
Magellan Representative:		Phone Number	