Merakey Pennsylvania ACT Referral Packet

As defined in the Office of Mental Health and Substance Abuse Services Bulletin (OMHSAS), Assertive Community Treatment (ACT) is a consumer-centered, recovery-oriented, mental health service delivery model that has received substantial empirical support for facilitating community living, psychosocial rehabilitation, are recovery for persons with the most serious mental illnesses and impairments who have not benefited from traditional outpatient programs.

Referrals to Merakey ACT Teams will be submitted by hospitals, jails/prisons, Long Term Structured Residences (LTSR), case management providers, Counties, Payers and other similar professional agencies supporting the individual identified as needing services. Please note that due to the intense level of treatment provided by ACT Teams, referrals not from a professional agency are not able to be accepted.

The attached packet will be completed in full by the referral source in collaboration with the consumer and provided to the ACT Team Leader, along with a psychiatric evaluation completed within the last 12 months. Any sections of the referral packet that are not relevant to the individual, please note N/A. Please note that referrals will not be reviewed for acceptance into the program until a completed referral is received.

The referral source will be contacted within 3 business days of the Team Leader receiving the completed referral with either a disposition or additional questions. And intake assessment will be scheduled within 5 business days of the decision and notification of acceptance. Should the individual be determined appropriate for the program, an intake date will be set up. If the individual does not meet program criteria, the referral source will be notified by call and receive written notification for their records.

ACT/FACT CRITERIA FOR ELIGIBILTY

Individual Name: _____ DOB: _____

NECESSARY CRITERIA-MUST HAVE BOTH 1 AND 2	
____ 1.	Age 18 or older
____ 2.	Has a diagnosis of Schizophrenia or chronic major mood disorder consistent with DSM 5 (and future revisions). Other mental health disorder may be appropriate in conjunction with symptoms presenting as chronic and persistent and can reasonably be expected to respond to therapeutic intervention. **Individuals with the primary diagnosis of substance use disorder, intellectual developmental disorder, or brain injury are not candidates for ACT.**
MUST HAVE AT LEAST TWO (2) OF THE FOLLOWING CRITERIA	
____ 3.	At least two (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
____ 4.	Intractable (i.e. persistent or very recurrent) severe major symptoms – i.e. affective, psychotic, suicidal.
____ 5.	Co-occurring mental illness and substance use disorders with more than six (6) month duration at the time of contact.
____ 6.	High risk or recent history of criminal justice involvement, which may include frequent contact with law enforcement personnel, incarcerations, parole or probation.
____ 7.	Literally homeless, imminent risk of being homeless, or residing in unsafe housing. **Homeless individual (literally homeless)** *is an individual who lives outdoors (street, abandoned or public building, automobile etc.) or whose primary residence during the night I a supervised public or private facility that provides temporary accommodations (short term shelter)*. **Homeless Individual (at imminent risk of being homeless)** *should meet at least one of the following criteria: doubled-up living arrangement where the individual's name is not on the lease, living in a condemned building without a place to move, arrears in rent/utility payments with no ability to pay, having received an eviction notice without a place to move, living in temporary or transitional housing that carries time limits, being discharged from a health care or criminal justice institution without a place to live.*
____ 8.	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.
____ 9.	Difficulty effectively utilizing traditional case management or office-based outpatient services or evidence that they require a more assertive and frequent non-office based services to meet their clinical needs.
EXCLUSION CRITERIA-EITHER OF THE FOLLOWING CRITERIA	
____ 1.	Individual is at imminent (immediate) risk of harm to self or others
____ 2.	Has impairment sufficient enough to require a level of service that is more intensive than community-based care.

Consumer Signature _____ Date _____

Referral Source Signature _____ Date _____

CONSUMER INFORMATION

Name (Last, First, Middle): _____

Maiden Name/Aliases: _____

DOB: _____ Social Security Number: _____ MA Number: _____

Address: _____
Is this safe/stable housing? ☐ yes ☐ no

Telephone Number: _____ home or cell
_____ home or cell

Gender: _____

Marital Status: _____

Primary Language: _____ Translation Services needed: _____

Identifying Information

Hair Color _____ Eye Color _____ Glasses _____

Hearing Aid _____ Height _____ Weight _____

Dentures: ☐ Upper ☐ Lower ☐ Needed ☐ Not Needed

Prosthesis: _____

Physical Limitations: _____

Emergency Contact

Name: _____

Address: _____

Telephone Number: : _____ home or cell
_____ home or cell

Relationship to Consumer: _____

Family/Natural Supports Involved in Treatment

Names	Relationship	Contact Information

Consumer's Strengths and Interests

Community Supports

REFERRAL INFORMATION

Referral Source Agency**:** _____

Contact Person and Role: _____

Contact Phone: _____ Contact Email: _____

Presenting Problem (Include consumer's input):

_____

_____

_____

_____

_____

Reason for Referral (Referral Source Clinical Justification):

_____

_____

_____

_____

_____

Current DSM-5 Diagnosis including ICD-10 codes:

_____	_____
code	diagnosis with specifier if applicable
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Treating Psychiatrist: _____

Diagnosis Date: _____

Location/Facility of Treatment/Diagnosis: _____

TREATMENT HISTORY

Current Providers

☐ Case Management

☐ Blended ☐ Drug and Alcohol ☐ Intensive ☐ Administrative

Agency: _____

Address: _____

Case Manager: _____

Contact Number: _____

☐ Outpatient Psychiatrist

Agency: _____

Address: _____

Contact Number: _____

Psychiatrist Name: _____

☐ Outpatient Therapist

Agency: _____

Address: _____

Contact Number: _____

Therapist Name: _____

☐ Peer Support Specialist

Agency: _____

Address: _____

Contact Number: _____

Contact Person: _____

☐ Supported Housing

Agency: _____

Address: _____

Contact Number: _____

Contact Person: _____

☐ Outpatient Drug and Alcohol

☐ IOP ☐ Group ☐ Individual Sessions

Agency: _____

Address: _____

Contact Number: _____

Contact Person: _____

☐ Family Based Services

Agency: _____

Address: _____

Contact Number: _____

Contact Person: _____

☐ Other _____

Agency: _____

Address: _____

Contact Number: _____

Contact Person: _____

☐ Other _____

Agency: _____

Address: _____

Contact Number: _____

Contact Person: _____

☐ Other _____

Agency: _____

Address: _____

Contact Number: _____

Contact Person: _____

HOSPITALIZATION HISTORY

Is the Consumer currently hospitalized? ☐ yes ☐ no
If yes, please complete contact information for current inpatient treatment team.

Current Hospital: _____

Social Worker: _____ Telephone: _____ Email: _____

Date of Admission: _____ Projected Discharge: _____

Psychiatric Hospitalizations within the last 12 months

Hospital Name	Dates of Admission	Type of Commitment (302 or 201)	Reason for Commitment

Any other significant information regarding hospitalization history that would be beneficial (periods of increase hospitalizations, triggers for hospitalizations, successes for hospital diversions)

Is the Consumer currently on an outpatient commitment? ☐ yes ☐ no

Will an outpatient commitment be part of their current discharge plan? ☐ yes ☐ no

MEDICATIONS

Is the Consumer able to identify and manage their medications independently? ☐ yes ☐ no

Consumer Pharmacy: _____

Current Medications ☐ Check if medication list is attached with all requested information

Medication	Dose	Frequency	Method	Reason for Taking	Requires Monitoring

Is the Consumer on any long acting injectable (LIA) medications? ☐ yes ☐ no
If yes, where do they currently go to receive the injection? _____

Is the Consumer being treated with Clozaril? ☐ yes ☐ no
If yes, please provide the follow questions:

When did they begin taking Clozaril? _____
How often are labs required? _____
Where are labs drawn? _____
Any irregular labs received? ☐ yes ☐ no If yes, when _____

Over the Counter Medications (including vitamins and as needed)

Medication	Dose	Frequency	Reason for Taking

Medication Allergies

Medication	Reaction

Anything that would be helpful to know regarding the Consumer and how they take their medications, including concerns of not taking medications.

_____
_____
_____
_____
_____
_____
_____

MEDICAL HISTORY

Current Providers

☐ Primary Care Physician

Physician/Practice: _____

Address: _____

Contact Number: _____

Contact Person: _____

☐ Dentist

Dentist/Practice: _____

Address: _____

Contact Number: _____

Contact Person: _____

☐ Gynecologist ☐ N/A-Male Consumer

Physician/Practice: _____

Address: _____

Contact Number: _____

Contact Person: _____

☐ Neurologist

Physician/Practice: _____

Address: _____

Contact Number: _____

Contact Person: _____

☐ Optometrist

Physician/Practice: _____

Address: _____

Contact Number: _____

Contact Person: _____

☐ Other Specialist _____

Physician/Practice: _____

Address: _____

Contact Number: _____

Contact Person: _____

☐ Other Specialist _____

Physician/Practice: _____

Address: _____

Contact Number: _____

Contact Person: _____

☐ Other Specialist _____

Physician/Practice: _____

Address: _____

Contact Number: _____

Contact Person: _____

☐ Other Specialist _____

Physician/Practice: _____

Address: _____

Contact Number: _____

Contact Person: _____

☐ Other Specialist _____

Physician/Practice: _____

Address: _____

Contact Number: _____

Contact Person: _____

MEDICAL CONDITIONS

Does the Consumer have any medical conditions? ☐ yes ☐ no If yes, please list

_____

_____

Medical Hospitalizations within the last 12 months

Hospital	Reason	New or Existing Condition?	Follow Up Care Needed?

SUBSTANCE USE HISTORY

Does the Consumer have a history of substance use? ☐ yes ☐ no
If no, this section does not need completed.

Substance	Frequency of Use	Method of Use	Date of First Use	Date of Last Use	Is Use Problematic for Consumer

Has the Consumer ever engaged in drug and alcohol treatment? ☐ yes ☐ no
If yes, provide brief treatment history information below

Treatment Facility	Dates of Treatment	Voluntary or Court Ordered	Residential or Outpatient	Completed (yes/no)

Is the Consumer currently receiving medically assisted treatment (MAT)? ☐ yes ☐ no

☐ Vivitrol Date Started _____ Facility Providing _____ Last inj _____
☐ Naloxone Date Started _____ Prescribing Physician _____
☐ Suboxone Date Started _____ Facility Providing _____ Dose _____
☐ Methadone Date Started _____ Facility Providing _____ Dose _____

LEGAL INVOLVEMENT

Is the Consumer have currently involved with the criminal justice system? ☐ yes ☐ no
If yes, complete the following section:

Current Involvement

Charge	Disposition	Follow up Required

Provide All Upcoming Court Hearing Dates and Times:

_____

Attorney Name and Contact Information (Include if Public Defender or Private Attorney):

_____

Probation/Parole Officer Name and Contact Information:

_____

Probation/Parole Requirements:

_____

Is the Consumer a Megan's Law Offender? ☐ yes ☐ no If yes, provide the following details

- ☐ Tier 1
- ☐ Tier 2
- ☐ Tier 3
- ☐ Pre-SORNA SVP (previous sexually violent predator)

Reporting requirements: _____

Past Legal History

Indicate if the Consumer has ever previously been convicted of and/or incarcerated for the following charges

☐ Aggravated Assault	☐ Incarcerated	☐ Domestic Violence	☐ Incarcerated
☐ Arson	☐ Incarcerated	☐ Sexual Offence	☐ Incarcerated
☐ Theft	☐ Incarcerated	☐ Drug Possession	☐ Incarceration
☐ Drug Distribution	☐ Incarcerated	☐ Fleeing/Eluding	☐ Incarceration
☐ Kidnapping	☐ Incarcerated	☐ Simple Assault	☐ Incarceration
☐ Fraud	☐ Incarceration	☐ Reckless Endangerment	☐ Incarceration

Total Number of Incarcerations: _____

Other significant information regarding the Consumer's legal/criminal history

_____

_____

_____

_____

_____

_____

FINANICIAL

Sources of Income

☐ SSI ☐ SSDI ☐ Paycheck ☐ Spouse's Income
☐ Survivor's Benefits ☐ Life Insurance Benefits ☐ Trust Fund ☐ Other _____

Total Monthly Income: _____ Average Monthly Spending: _____

Does the Consumer have a Representative Payee? ☐ yes ☐ no If yes, provide the following details
Is the payee required by a psychiatrist? ☐ yes ☐ no
Payee Name: _____
Agency or Relationship to Consumer: _____
Telephone Number: _____
If the Consumer does not have a payee, would they benefit from having one? ☐ yes ☐ no
Are they open to having a payee? ☐ yes ☐ no

Does the Consumer have a Legal Guardian? ☐ yes ☐ no If yes, provide the following details
Contact information
Name: _____ Agency: _____
Telephone Number: _____ Email: _____
Date Guardianship took effect: _____ End Date (if applicable): _____
A copy of the Guardianship paperwork will need to be provided to the Team

Does the Consumer have a Power of Attorney ☐ yes ☐ no If yes, provide the follow details
What does the POA specifically cover? _____
Contact Information
Name: _____ Agency or Relationship: _____
Telephone Number: _____ Email: _____
Effective Dates: _____
A copy of the Power of Attorney paperwork will need to be provided to the Team