Central Minnesota Mental Health Center
Assertive Community Treatment Team
Referral Information Form

Date of Referral: **County of Financial Responsibility:**

Recipient Name: **County of Residence:**

Legal Address: **Phone:**

Date of Birth: **Social Security #**

Medical Assistance: ☐ Yes ☐ No Type: **MA #:**

Other Insurance:

Referral Source: **Referent's Phone Number:**

Reason for referral:

Is the client aware and in support of this referral? ☐ **Yes** ☐ **No**

DIAGNOSIS

Most Recent Diagnostic Assessment Date: **Completed By:**

DSM 5:

DSM 5:

DSM 5:

DSM 5:

CURRENT SERVICE PROVIDERS / INVOLVED PERSONS

County Social Worker: Agency: Phone:

Is the county social worker aware of this referral? ☐ Yes ☐ No **In support of referral?** ☐ Yes ☐ No

Psychiatrist: Clinic: Phone:

Is the psychiatrist aware of this referral? ☐ Yes ☐ No **In support of referral?** ☐ Yes ☐ No

Therapist: Clinic: Phone:

Is the therapist aware of this referral? ☐ Yes ☐ No **In support of referral?** ☐ Yes ☐ No

Financial Worker: Agency: Phone:

Representative Payee: Agency: Phone:

ARMHS Worker: Agency: Phone:

Guardian/Conservator: Phone:

Other: Phone:

Other: Phone:

Other: Phone:

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Current Medications:

Current living situation:

Funding: GRH ☐ Yes ☐ No **CADI** ☐ Yes ☐ No **Other** (Specify):

Support services not funded:

Current sources of income:

Is the recipient under a civil commitment? ☐ **Yes** ☐ **No** **Type:** **Expiration date:**

Based on the individual's history and your current assessment, what duration of time do you believe intensive services will be needed to stabilize the recipient's mental health symptoms?

☐ **Three months or less** ☐ **3-6 months six months – 1 yr** ☐ **1-2 yrs** ☐ **over two years**

SUPPORTING DOCUMENTATION

The following supporting documentation should be included with this referral form. Please check all that is included:

- ☐ Release of Information
- ☐ Psychiatric assessment
- ☐ Current medication list
- ☐ Current assessments
  - ☐ Functional assessment
  - ☐ Diagnostic assessment
  - ☐ Other pertinent clinical assessments
- ☐ Case management / Treatment plan (most recent)
- ☐ Additional relevant treatment information (support services)
  - ☐ Mental health treatment
  - ☐ Medical
  - ☐ Employment
  - ☐ Housing
  - ☐ Education
  - ☐ Financial/benefits
- ☐ Crisis/Safety Plan
- ☐ Legal: Documentation of civil commitment / criminal history (current or past)
- ☐ Guardian / Conservatorship documentation

REFERRAL PROCESS

This referral form and any supporting documentation should be sent to:
Stearns County: Ashley L. Anderson Fax: 320-253-4179; Mail: 411 3rd St North Suite 4, Waite Park, MN 56387, or e-mail to alanderson@cmmhc.org
Wright County: Fax: 763-271-5350; Mail: 407 Washington Street, Monticello, MN 55362.
Sherburne & Benton County: Fax: 763-274-1165; Mail: 11090 183rd Cir NW Unit B, Elk River, MN 56330

Our programs intend to gather as much current and past clinical information as possible before admission to ensure that potential clients and current treatment providers are fully informed of services provided by ACT as well as to safeguard against inappropriate admissions. In addition, the referral phase of services allows the client to identify a vision for recovery and realize how our programs may help work toward recovery. The referral process is a joint activity with the client, the client's current treatment provider (e.g., referral source), any members of the client's natural support network identified by the client, and members of our teams.

Once referral information is received, we will contact you to discuss further our programs and this recipient's eligibility. If you have other questions regarding our programs, please do not hesitate to contact the respective team leads; Ashley L. Anderson, Stearns County 320-253-4120; Wright County (763)271-5340, and (Sherburne/Benton) at 763-274-3500

Additional eligibility criteria for the ACT program are included on the following page. Thank you for your referral.

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An eligible client for assertive community treatment is an individual who meets the following criteria as assessed by an ACT team:

(1) Is age 18 or older. Individuals ages 16 and 17 may be eligible upon approval by the commissioner;

(2) Has a primary diagnosis of schizophrenia, schizoaffective disorder, major depressive disorder with psychotic features, other psychotic disorders, or bipolar disorder. Individuals with other psychiatric illnesses may qualify for assertive community treatment if they have a serious mental illness and meet the criteria outlined in clauses 3 and 4, but no more than ten percent of an ACT team's clients may be eligible based on this criteria. Individuals with a primary diagnosis of a substance use disorder, intellectual developmental disabilities, borderline personality disorder, antisocial personality disorder, traumatic brain injury, or an autism spectrum disorder are not eligible for assertive community treatment;

(3) Has significant functional impairment as demonstrated by at least one of the following conditions:

(i) significant difficulty consistently performing the range of routine tasks required for basic adult functioning in the community or persistent difficulty performing daily living tasks without significant support or assistance;

(ii) significant difficulty maintaining employment at a self-sustaining level or significant difficulty consistently carrying out the head-of-household responsibilities; or

(iii) significant difficulty maintaining a safe living situation;

(4) Has a need for continuous high-intensity services as evidenced by at least two of the following:

(i) two or more psychiatric hospitalizations or residential crisis stabilization services in the previous 12 months;

(ii) frequent utilization of mental health crisis services in the previous six months;

(iii) 30 or more consecutive days of psychiatric hospitalization in the previous 24 months;

(iv) intractable, persistent, or prolonged severe psychiatric symptoms;

(v) coexisting mental health and substance use disorders lasting at least six months;

(vi) recent history of involvement with the criminal justice system or demonstrated risk of future involvement;

(vii) significant difficulty meeting basic survival needs;

(viii) residing in substandard housing, experiencing homelessness, or facing imminent risk of homelessness;

(ix) significant impairment with social and interpersonal functioning such that basic needs are in jeopardy;

(x) coexisting mental health and physical health disorders lasting at least six months;

(xi) 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;

(xii) requiring a residential placement if more intensive services are not available; or

(xiii) difficulty effectively using traditional office-based outpatient services;

(5) There are no indications that other available community-based services would be equally or more effective as evidenced by consistent and extensive efforts to treat the individual; and

(6) In the written opinion of a licensed mental health professional, has the need for mental health services that cannot be met with other available community-based services, or is likely to experience a mental health crisis or require a more restrictive setting if assertive community treatment is not provided.