ACTT REFERRAL FORM

Client Name: ____

Client Date of Birth: ____

Target population for ACT services are beneficiaries (ages 18 and over) with severe and persistent mental illness; priority is given to people with schizophrenia, other psychotic disorders (e.g., schizoaffective disorder), and bipolar disorder because these illnesses more often cause long-term psychiatric disability. Beneficiaries with other psychiatric illnesses are eligible dependent on the level of the long-term disability. *Individuals with a primary diagnosis of a substance abuse disorder, intellectual/developmental disabilities, borderline personality disorder, traumatic brain injury, or an autism spectrum disorder are not the intended client group and should not be referred to ACT if they do not have a co-occurring psychiatric disorder.*

A. The individual has a current DSM 5 diagnosis consistent with a serious and persistent mental illness reflecting the need for treatment and the covered treatment must be medically necessary for meeting the specific preventive, diagnostic, therapeutic, and rehabilitative needs of the beneficiary.

    Primary Diagnosis (with code):____________________

AND

B. The beneficiary has significant functional impairment as demonstrated by *AT LEAST ONE* of the following conditions:

☐ Significant difficulty consistently performing the range of routine tasks required for basic adult functioning in the community (for example, caring for personal business affairs; obtaining medical, legal, and housing services; recognizing and avoiding common dangers or hazards to self and possessions; meeting nutritional needs; attending to personal hygiene) or persistent or recurrent difficulty performing daily living tasks except with significant support or assistance from others such as friends, family, or relatives

    Specific examples:

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☐ Significant difficulty maintaining consistent employment at a self-sustaining level or significant difficulty consistently carrying out the head-of-household responsibilities (such as meal preparation, household tasks, budgeting, or child- care tasks and responsibilities)

    Specific examples:

____

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☐ Significant difficulty maintaining a safe living situation (for example, repeated evictions or loss of housing or utilities)

Specific examples:

AND

C. **The beneficiary has *ONE or MORE* of the following problems, which are indicators of continuous high-service needs:**

☐ High use of acute psychiatric hospital (2 or more admissions during the past 12 months) or psychiatric emergency services

Specific examples:

☐ Intractable (persistent or recurrent) severe major psychiatric symptoms (affective, psychotic, suicidal, etc.)

Specific examples:

☐ Coexisting mental health and substance abuse disorders of significant duration (more than 6 months)

Additional diagnosis:

☐ High risk or recent history of criminal justice involvement (such as arrest, incarceration, probation)

Specific examples:

☐ Significant difficulty meeting basic survival needs, residing in substandard housing, homelessness, or imminent risk of homelessness

Specific examples:

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☐ 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

Specific examples:

☐ Difficulty effectively using traditional office-based outpatient services

Specific examples:

AND

D. There are no indications that available alternative interventions would be equally or more effective based on North Carolina community practice standards and within the LME-MCO service array

☐ Options for alternative services reviewed and determination was made that no other services are available that **would meet the individual's current** level of services needs

Specific examples:

Additional Comments:

Name and contact information of person completing form/referring agency:

Please fax the following documentation to 828-350-0802

☐ Current/recent CCA or Psychiatric Evaluation
☐ Release of Information Signed by Client or Legal Representative
☐ ACTT Service Definition Checklist (this document)
☐ October Road Referral Form

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