ACTT Referral Form

Client Name: _____

Client Date of Birth: _____

A. 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.

Primary Diagnosis: _____

AND

B. Functional impairment as demonstrated by ***AT LEAST ONE*** of the following:

☐ Significant difficulty consistently performing the range of routine tasks required for basic adult functioning in the community or persistent or recurrent difficulty performing daily living tasks except with significant support or assistance from others such as friends, family, or relatives

☐ Significant difficulty maintaining consistent employment at a self-sustaining level or significant difficulty consistently carrying out the head-of-household responsibilities

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

AND

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

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

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

☐ 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)

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

☐ 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

☐ Difficulty effectively using traditional office-based outpatient services

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
☐ October Road Referral Form

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