lower shore clinic

Assertive Community Treatment (ACT)

Serving: Somerset, Worcester, Wicomico, Dorchester, Talbot, Caroline Counties

Referral Questions: 443-859-7774

Please submit referrals to referral@lowershoreclinic.org or fax to 410-341-3397

Checklist for Individuals who meet basic criteria for ACT

ACT is designed for adults with severe mental illness who are most at-risk of psychiatric crisis and hospitalization and involvement in the criminal justice system. ACT is a multidisciplinary team approach with assertive outreach in the community and are available to the consumer on a 24/7 basis.

Admission Criteria:

All of the following criteria are necessary for admission:

1. **The consumer has a PMHS specialty mental health diagnosis included in the Priority Population List, which is the cause of significant psychological, personal care, and social impairment. Please include all that apply:**

☐	F20.9	Schizophrenia	F31.13	BP1 Disorder, MRE Manic, Severe
☐	F20.81	Schizophreniform Disorder	F31.2	BP1 Disorder, MRE Manic, w/Psychotic Features
☐	F25.0	Schizoaffective Disorder, BP Type	F31.4	BP1 Disorder, MRE Depressed, Severe
☐	F25.1	Schizoaffective Disorder, Depressed	F31.5	BP I Disorder, MRE Depressed, w/ Psychotic
☐	F28	Other Specified Schizophrenia Spectrum	F31.0	BP 1 Disorder, MRE Hypomanic
☐	F29	Unspecified Schizophrenia Spectrum	F31.9	BP 1 Disorder Unspecified
☐	F22	Delusional Disorder	F31.81	BP II Disorder
☐	F33.2	MDD, MRE Severe	F60.3	Borderline Personality Disorder
☐	F33.3	MDD, MRE Severe, with psychotic	F21	Schizotypal Personality Disorder

2. **The impairment results in at least one of the following:**
   - ☐ A clear, current threat to the Individual's ability to live in his/her customary setting, or the Individual is homeless, and would meet the criteria for a higher level of care if mobile treatment services were not provided. The individual is homeless.
   - ☐ An emerging/impending risk to self or others.
   - ☐ Inability to engage in traditional outpatient treatment.

3. **Inability to form a therapeutic relationship on an ongoing basis as evidenced by at least one of the following:**
   - ☐ Frequent use of emergency rooms for psychiatric reasons.
   - ☐ Psychiatric hospitalizations
   - ☐ Arrest for reasons associated with the Individual's mental illness.

Referral Process

1. Within 10 working days of receiving a complete referral, the Assertive Community Treatment Team will arrange for staff to visit applicant to conduct a face to face screening assessment to determine needs, strengths, available resources, and willingness to participate in the Assertive Community Treatment Services offered.
2. Within 5 working days of the screening assessment, the individual and the referral source will be notified whether the Assertive Community Treatment Team:
    a. Accepts the individual and will begin enrollment process
    b. Will accept the individual, following an updated review of the individual's eligibility, when when program capacity permits.
    c. Denies services due to ineligibility.
    d. Will accept the individual, following an updated review of the individual's eligibility, after the individual's discharge or release from an inpatient facility or detention center.

Release and Authorization

I, _____, authorize the release/exchange of all available information between the following agencies/individuals to support my application to Lower Shore Clinic, Inc. If services are terminated or denied, I authorize the release of information pertaining to the denial or termination, including the reason for these actions, effective date, and, when appropriate, discharge plans.

This Release/Authorization Form is effective for 90 days

Emergency Contact: _____ Phone Number: _____

Address: _____ Relationship: _____

Mental Health Provider: _____ Phone Number: _____

Somatic Provider: _____ Phone Number: _____

Referring Agency: _____ Phone Number: _____

Referring Individual: _____ Phone Number: _____

I understand that application for Assertive Community Treatment Services is being made on my behalf and agree to this referral for services.

Signed: _____ Date: _____

Witness: _____ Date: _____

Referral Form

Client Name: _____ Date of Referral: _____

Date of Birth: _____ Social Security Number: _____

Sex: ☐ Male ☐ Female Gender Identity: _____ Currently Inpatient: ☐ Yes ☐ No

Current Living Arrangement: (If inpatient, living arrangement prior to hospitalization)

☐ Lives Alone ☐ Lives with family/friend ☐ Homeless ☐ RRP ☐ Other _____

Address: _____

Mobile Phone: _____ Home Phone: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed # Children _____

Ethnic Group: ☐ African American ☐ Hispanic ☐ White Non-Hispanic ☐ Asian/Pacific Island

☐ American Indian/Alaska Native ☐ Other _____

Current Entitlement Information

☐ Social Security Amount _____ ☐ PAA Amount _____

☐ SSI Amount _____ ☐ VA Benefits Amount _____

☐ SSDI Amount _____ ☐ Salary/Wages Amount _____

☐ Other Income: Type: _____ Amount: _____

☐ Medicaid ID Number _____ ☐ Medicare ID Number _____

Current ICD 10 Diagnoses

Behavioral Diagnoses: _____

Primary Medical Diagnoses: _____

Social Elements Impacting Diagnosis: ☐ Financial ☐ Social Environment ☐ Occupational ☐ Legal

☐ Primary Support Group ☐ Housing ☐ Homelessness ☐ Access to Healthcare

Currently Medication Compliant: ☐ Yes ☐ No ☐ With Reminders

Medications Currently Prescribed, if known, as well as who prescribed. You may attach a separate sheet:

_____

_____

_____

_____

Currently Compliant with Outpatient Mental Health Appointments ☐ Yes ☐ No

Barriers to Outpatient Treatment _____

_____

_____

Presenting Problems: (Check all that apply and provide elaboration)

☐ Visual or Hearing Impairment: Explain _____

☐ Physical Disability: Explain _____

☐ Chronic Health Problems/Somatic Issues _____

☐ Special Dietary Needs _____

☐ Drug or Alcohol Abuse Explain: _____

_____

_____

☐ Social/Interpersonal Conflicts, Including Marital and Family Problems _____

_____

☐ Hallucinations/Delusions _____

_____

☐ Depression/ Mood Disorder _____

_____

☐ Suicide Threat/Attempts/Self Harm, Include date of most recent occurrence _____

_____

_____

☐ Homicidal Threat/Attempt/_____

_____

☐ Violent/Assaultive Behavior _____

_____

☐ Other: Include specific detail _____

_____

Access to Weapons: ☐ Yes ☐ No ☐ Unknown If yes, please list _____

_____

Level of Functioning: Able to Read ☐ Yes ☐ No Able to Write ☐ Yes ☐ No

Highest grade completed, if known _____ Special Education ☐ Yes ☐ No

Psychiatric Hospitalization History **Number of Hospitalizations (Lifetime) _____**

3 Most Recent Hospitalizations

Institution _____ Date _____

Institution _____ Date _____

Institution _____ Date _____

Reasons for hospitalizations _____

_____

_____

Forensic Status ☐ No Forensic Status ☐ Conditional Release ☐ Parole/Probation ☐ Not Criminally Responsible

Conditions of Probation/Parole/ Pending Charges _____

_____

_____

Probation/Parole Contact Information _____

Treatment History: Has the individual been referred to or participated in any of the following? If yes, where and when?

☐ Outpatient Addictions Treatment _____

☐ Inpatient Addictions Treatment _____

☐ Dual Diagnosis Treatment _____

☐ Outpatient Mental Health Treatment _____

☐ Psychiatric Rehabilitation Program, Including Residential Rehabilitation/Supervised Housing _____

_____

☐ Supported Employment _____

☐ Targeted Case Management _____

Social History

Employment History: Include all past jobs and reasons for leaving them, also include volunteer positions:

_____

_____

Family History Include information about support system, family history of mental illness, siblings, family structure, and significant others as well as living situation _____

_____

_____

Community Include agency contacts, court involvement, church, social groups, support system

_____

_____

Reason for Referral: Include risks to self and others, risk for hospitalization or incarceration, difficulty with outpatient treatment engagement, Emergency Room Use, Hospitalization History, all other helpful information

_____

_____

_____

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