ACT Referral

Instructions and Checklist

- Fill out the OHA Assertive Community Treatment (ACT) Universal Referral Form on the following pages.
- Supporting documentation is required. Submit any supporting clinical documentation files along with your referral form. Please read the form instructions carefully, and fill it out completely before submitting.
- Fill out the information and checklist below to ensure your submission is complete.
- Email completed form to actreferrals@gobhi.org

Name of sender: _____

Date sent: _____

Number of pages: _____

Did you email supporting documentation?	☐ Yes	☐ No
Did you include the county the client will reside in?	☐ Yes	☐ No
Is this a denial?	☐ Yes	☐ No
If this is a denial, did you send denial to um@gobhi.org with supporting documents?	☐ Yes	☐ No

Please email completed form to actreferrals@gobhi.org

Name of participant: _____
Date of birth: _____
Prime number (*if applicable*): _____

Oregon Health Authority
HEALTH SYSTEM DIVISION

Assertive Community Treatment (ACT)

Universal Referral Form

Date form is sent: _____
Referring party name and title: _____
Referring party agency contact information: _____

Type of request:

☐ **New referral:** Clinical notes attached? ☐ Yes ☐ No. If no, why? _____
☐ **Transfer.** ACT Program Transferring from and contact: _____

Current location: _____ Participant phone number: _____
Address/anticipated address: _____
Anticipated county to reside: _____
Gender identity preferences: _____
Cultural identity: _____ If Tribal, what tribe: _____
Linguistic preferences: _____
Guardian primary contact: _____ Guardian phone number: _____
Home CCO/insurance type: _____
Primary mental health diagnosis: _____
Most recent clinical assessment: _____
Who completed assessment: _____
Aid and assist: ☐ Yes ☐ No Anticipated discharge date: _____

Note: per OAR 309-019-0245(1)(b), Individuals with a primary diagnosis of a substance use disorder, borderline personality disorder, autism spectrum or intellectual disabilities are not the intended population for ACT.

1. Does the client exhibit significant functional impairments as demonstrated by at least one of the following conditions?

   ☐ Significant difficulty consistently performing the range of practical daily living tasks required for basic adult functioning in the community (*e.g., caring for personal business affairs; obtaining medical, legal, or housing services; recognizing and avoiding common dangers or hazards to self and possessions; meeting nutritional needs, maintaining personal hygiene.*) Briefly describe:

   _____

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☐ Significant difficulty maintain consistent employment at a self-sustaining level or significant difficulty consistently carrying out the homemaker role (*e.g., household meal preparation, washing clothes, budgeting, or child-care tasks and responsibilities*). Briefly describe:

_____

☐ Significant difficulty maintaining a safe living situation (*repeated evictions or loss of housing*). Briefly describe:

_____

2. Does the client have a secondary co-occurring disorder that also impacts their ability to function in the community?
   Substance use disorder: ☐ Yes ☐ No. If yes, please list: _____
   Other co-occurring disorder: ☐ Yes ☐ No. If yes, please list: _____

3. Client with one or more of the following indicators of continuous high service needs (*check all that apply*):
   - ☐ High use of acute psychiatric hospitals (Two or more admissions per year) or psychiatric emergency services.
   - ☐ Intractable (e.g., persistent, or very recurrent) severe major mental health symptoms (*affective psychotic, suicidal*).
   - ☐ Coexisting substance use disorder of significant duration (*greater than six months*).
   - ☐ High risk or recent history of criminal justice involvement (*e.g., arrest, incarceration*).
   - ☐ Significant difficulty meeting basic survival needs, residing in substandard housing, houselessness, or imminent risk becoming houseless.
   - ☐ Residing in a 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 utilizing traditional office-based outpatient services.

Additional information
(*Other programs involvement/referrals or any other identifying factors that will assist in transition*)

ACT program (or SPOC) determination

Date referral received: _____

Accepted for next steps of review:

- Anticipated date of intake/screening evaluation: _____
- Waitlisted: ☐ Yes ☐ No

Pending (*list reason for selecting this*): _____

Denied (*list relevant OAR's*): _____

- If denied, please identify alternative recommendations of community-based services to be provided:

_____ _____

Signature of ACT Services Representative **Date**

(*Whomever made final determination*)

You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact Adult Mental Health Program at languageaccess.info@odhsoha.oregon.go or 1-844-882-7889 (voice). We accept all relay calls.

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