Merakey Behavioral Health

REFERRAL FORM FOR F/ACT

260 Ohio River Blvd. Baden, PA 15005 **Please check all areas that apply**

Date: _____ Individual's Name: _____ Date of Birth:_____ SS#: _____-____-_____

ADMISSION CRITERIA

Following are the eligibility requirements for Assertive Community Treatment Services: A. 18 years of age or older and B. individuals who have been diagnosed with a serious and persistent mental illness. A person shall be considered to have a serious and persistent mental illness when all of the following criteria for diagnosis, functioning level, and treatment history are met.

Must Meet Criteria I, II and one or more of Criteria III

I. DIAGNOSIS

Primary diagnosis of Schizophrenia or other Psychotic Disorders such as Schizoaffective Disorder, or Chronic Major Mood Disorder as defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM IV-R or any subsequent revisions thereafter). Individuals with a primary diagnosis of a Substance Use Disorder, Mental Retardation, or Brain Injury are not the intended consumer group; **AND**

II. FUNCTIONING LEVEL

Global Assessment of Functioning Scale (as specified in the DSM IV-R or revisions thereafter) ratings of 40 or below, OR, GAF Rating of 60 or below if the individual is 35 years of age or younger and has a documented history of violent or aggressive behavior; **AND**

III. INDICATORS OF CONTINUOUS HIGH SERVICE NEEDS: (Must have [a] OR [b] AND [c])

___ a. Three (3) or more psychiatric and/or substance abuse hospitalizations; OR, one (1) psychiatric hospitalization over thirty (30) days in the past twelve (12) months;

___ b. For a forensic team, one (1) psychiatric hospitalization, or, documented evidence by a psychiatrist that behavioral health services were provided in the last 12 months, AND one (1) incarceration of more than six (6) months, or three (3) jail detentions in a twelve (12) month period.

___ c. Inability to participate or remain engaged or respond to traditional community based services. (Documented evidence exists demonstrating efforts to engage the individual by a treatment or case management provider for forty-five (45) days and supporting documentation that without behavioral health treatment and support, the individual's well being and stability will be jeopardized) **AND**

At least two (2) of the following criteria:

___ a. Co-occurring mental illness and substance use disorders with more than six months duration at the time of contact.

___ b. Intractable, persistent or very recurrent severe major symptoms (ex., affective, psychotic, or suicidal with inability to ignore; or, life threatening physical harm to self or others with or without follow through; or, impulsive acting out, physical assault or uncontrolled anger that resulted in physical harm or real potential harm to others (ex., assault, rape, arson);

___ c. Lack of support system; limited to no support from family, other professionals, friends, and social programs;

___ d. History of inadequate follow-through with elements of a treatment/service plan that resulted in psychiatric or medical instability (lack of follow through taking medication, following a crisis plan, attending to health needs, or maintain housing);

___ e. Literally homeless, imminent risk of being homeless, or residing in unsafe housing; or, 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 provided.

EXCEPTION CRITERIA

Any individual who needs to receive F/ACT services, but does not meet the requirements identified above may be eligible for F/ACT services upon written prior approval by the Value Behavioral Health Managed Care Organization or Beaver County Behavioral Health, as applicable.

OUTSIDE AGENCIES

Agency Name: _____ Agency Phone: _____

Address: _____

_____

Please have individual sign Release of Information for your agency and fax with referral form to 724-869-2029, Attn F/ACT

Individual Signature: _____ **Date:** _____

Clinician Signature: _____ **Date:** _____

___ **Individual accepted into program** **Signature:** _____ **Date:** _____

___ **Individual not accepted into program** **Signature:** _____ **Date:** _____