Assertive Community Treatment (ACT)
Referral Guide and Referral Form

Program Description

Assertive Community Treatment (ACT) is an evidence-based practice that provides community-based, multidisciplinary mental health treatment for individuals with severe and persistent mental illness. The goal of ACT is to lessen or eliminate the debilitating effects that the symptoms of mental illness can have on functioning and quality of life by providing the majority of treatment, rehabilitation, and support services that individuals need to achieve their goals and live independently in their community.

ACT services are tailored for each person and address their preferences and identified goals established through relationship building and individualized assessments. The teams work collaboratively to provide services in community locations that can be available 24 hours a day and 365 days a year. The services that the teams are required to provide include:

- Service coordination
- 24-hour crisis assessment and intervention
- Symptom assessment and management
- Medication prescription, administration, monitoring, and documentation
- Co-occurring substance use services
- Employment services
- Activities of daily living
- Social/interpersonal relationship and leisure-time skill training
- Peer support services
- Support services
- Education, support, and consultation to families

Admission Criteria

Patients **must meet all seven** of the admission criteria:

1. A primary diagnosis of schizophrenia or other psychotic disorders, such as schizoaffective disorder or bipolar disorder, as defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM V or any subsequent revisions thereafter). Individuals with a primary

diagnosis of substance use disorder, intellectual disability, or brain injury are not the intended consumer group.

2. Must be 18 years of age or older.
3. At least two or more acute episodes of psychiatric inpatient treatment within the past 12 months or 30 days or more on an acute psychiatric unit or State Hospital during the last 12 months, or three or more contacts with crisis intervention/emergency services within the past six months.
4. Significant difficulty meeting basic survival needs, residing in substandard housing, homelessness, or imminent risk of becoming homeless.
5. The individual does not have a primary diagnosis of a Personality Disorder, Traumatic Brain Injury, or Intellectual Disability.
6. Difficulty effectively utilizing traditional community-based services: outpatient, case management, etc.
7. History of inadequate follow through with elements of a treatment/service plan that resulted in member psychiatric or medically instability. OR
8. The individual does not meet all of the admission criteria described above, but is designated as appropriate to receive ACT services by a multidisciplinary team, which includes participation by representatives of CBH Clinical Management in consultation with an ACT provider, CBH physician advisor, or the county Office of Behavioral Health.

ACT Providers

There are three ACT providers: **CTT (3 teams), Horizon House(1 team) and PATH (1 team)**. Contact information for each of these providers is listed below. If sending to CTT, please click directly on the link to complete the electronic referral. If sending to Horizon House or PATH, complete referral and email directly to email address indicated.

ACT Provider	Primary ACT Contact	Contact Email
CTT	cttadmissions@pmhcc.org	https://pmhcc.formstack.com/forms/act
Horizon House	Rashidah Inge	HHPhilaACTReferals@hhinc.org

PATH	Makalay Tarawally	actreferrals@pathcenter.org

For more information about ACT services, please contact Elisabeth Caba, BHCMU Supervisor at Elisabeth.Caba@Phila.gov.

Assertive Community Treatment (ACT) Cover Sheet

Send this cover sheet as a scanned copy to Community Treatment Teams (CTT) OR Horizon House along with the complete Referral Form packet for all ACT applicants (Choose one)

Email the Completed Referral Form Packet to:

___**CTT**: https://pmhcc.formstack.com/forms/act

☐	Act 1 – Forensic	For participants with significant forensic involvement
☐	Act 3 - Acute Care	For participants who are heavy utilizers of acute services
☐	Act 4 - Young Adults	For younger participants

___**Horizon House:** HHPhilaACTReferals@hhinc.org

☐	Generic ACT	High Utilizers

___**PATH:** actreferrals@pathcenter.org

☐	Generic ACT	High Utilizers

*** Mailed or faxed referrals will NOT be reviewed. ***

FROM:

Referring Agency/Program: _____

Referring Staff's Name/Person Completing Form: _____

Contact Phone: _____ Fax: _____

Referring Staff's Email: _____

Other Case Managers: _____ Contact Info: _____

ACT Referral is being requested for:

Applicant's Last Name: _____ First Name: _____

Applicant's D.O.B.: _____ SS#: _____

Consent to Release Information

I authorize the disclosure of the ACT Application and all related supporting documents, including confidential medical and mental health information, to Community Treatment Teams Philadelphia, Horizon House or PATH for the purposes of assessment for ACT services. I understand that I may revoke this authorization at any time. My revocation must be in writing. I am aware that my revocation will not be effective if the persons I have authorized to use and/or disclose my protected health information have already taken action because of my earlier authorization. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment nor will it affect my eligibility for benefits.

Applicant _____

Print Name Signature Date

Witness _____

Print Name Signature Date

ACT Application Packet Instructions

The ACT Application Packet consists of 2 forms as well as supporting documentation. A completed application must include the following (check all boxes to indicate paperwork is attached):

☐	The ACT Cover Sheet with signed consent to release information.
☐	A completed ACT Referral Form. Please answer all questions; type answers when possible or write legibly.
☐	A Comprehensive Biopsychosocial Evaluation (CBE) or ADAPT Assessment completed within the last year for cases directly referred from Extended Acute Care service (EAC).
☐	A Comprehensive Psychiatric Evaluation signed by a Psychiatrist or a Psychiatric Nurse Practitioner and completed within the last 30 days for acute inpatient or EAC referrals.

ACT Referral Summary

Medical Necessity Criteria (MNC) must be met for eligibility for ACT Services. Answer questions below and use additional pages if necessary.

1. Provide a brief statement regarding applicant's current level of functioning including mental status, relationship with family, community supports, etc.

2. Does the applicant have a primary diagnosis of schizophrenia or other psychotic disorder (schizoaffective disorder or bipolar disorder)?* ☐ Yes ☐ No ☐ Unknown
   If "Yes", please describe the symptoms and history that led to this applicant receiving a primary diagnosis of schizophrenia, schizoaffective disorder or bipolar disorder.

3. Does the applicant have at least two or more acute episodes of psychiatric inpatient treatment within the past 12 months or 30 days or more on an acute psychiatric unit or State Hospital during the last 12 months, or three or more contacts with crisis intervention/emergency services within the past six months?* ☐ Yes ☐ No ☐ Unknown

   If "Yes" please describe the psychiatric hospitalizations over the past 12 months including the precipitating factors that led to admission (i.e. harm to self, harm to others, inability to care, voluntary commitment) and responsiveness to treatment. Please describe the applicant's utilization of crisis intervention/emergency services over the past 6 months including patterns of behavior that led to contacts.

4. Does the applicant have significant difficulty meeting survival needs, residing in substandard housing, homelessness, or imminent risk of becoming homeless? * □ Yes □ No □ Unknown
   If "Yes" please describe.

5. Does the applicant have a previous or current diagnosis of a Personality Disorder, Traumatic Brain Injury or Intellectual Disability? * □ Yes □ No □ Unknown
   Is this considered a primary diagnosis? □ Yes □ No
   What factors (for example, behaviors, functional deficits, etc.) led to this diagnosis?

6. Has the applicant had difficulty effectively utilizing community-based services: PCP appointments, outpatient therapy, medication management, medication adherence / non-adherence and consequences, case management, drug and alcohol services, etc.?*
   □ Yes □ No □ Unknown

   If "Yes", please describe these difficulties (e.g. engaged, rarely attended, never attended, or refused services).

7. What community-based supports and interventions/strategies (e.g. Outpatient, Inpatient Rehab, IOP, etc …) have been attempted within the last 12 months to engage and/or link the applicant to community behavioral health services?

8. Has the applicant had a history of inadequate follow through with elements of a treatment/service plan that resulted in member psychiatric or medical instability?* □ Yes □ No □ Unknown
If "Yes", please describe applicant's typical obstacles to following through with treatment/service planning.

9. Please describe the applicant's health/medical status, including conditions, adherence with medication and medical treatments, and impact on applicant's overall day to day function and may put applicant at risk in the community.

Print Name: _____ Title: _____

Signature: _____ Date: _____

Email address: _____ Phone #: _____

ACT Referral Form

Date of Referral Form: _____ Person Completing Form: _____

Section A: Demographics

	First Name:		Last Name:	
	DOB:		SS#:	
	Applicant Address: _____ _____ _____ *If the applicant is homeless please note the shelter/drop in center or location where they may be contacted. *Determination cannot be made without an address to locate the participant			
	Participant Telephone #:			
	Emergency Contact:		EC Phone:	
	Relationship to EC:			
	CIS#:	BSU#:	Medicaid #	
	Gender:	☐ Male ☐ Female ☐ Transgender ☐ Other		
	US Veteran:	☐ Yes ☐No If yes, branch of service:		
	Available forms of government issued ID: ☐ Photo ID ☐ Social Security Card ☐ None ☐ Birth Certificate ☐ Permanent Resident Card ☐Other: _____			
	PP# (Philadelphia County Jail Police Photo #):			
	Applicant's Race (check all that apply): ☐ Black / African American ☐ Asian ☐ White ☐ Native Hawaiian / Pacific Islander ☐ American Indian / Alaskan Native ☐ Other/Unknown: _____			
13.	Applicant's Ethnicity (check all that apply): ☐ Hispanic / Latino ☐ Non-Hispanic / Latino ☐ Unknown			

	Primary Language: ☐ English ☐ Spanish ☐ Mandarin ☐ Cantonese ☐ Vietnamese ☐ Hindi ☐ Cambodian (Khmer) ☐ ASL ☐ No language ☐ Other: _____
	Participant's English Proficiency: ☐ Does not speak ☐ Poor ☐ Fair ☐ Good ☐ Excellent
16.	Highest level of education completed: _____

If applicant is hospitalized and being discharged to a different address or if the applicant is homeless and moving into housing, please indicate the address/contact information they will be transferred to:

_____

Telephone #: _____

Section B: Family Contacts

	Marital Status: ☐ Single, never married ☐ Married ☐ Widowed ☐ Cohabitating ☐ Divorced / Separated ☐ Unknown ☐ Other: _____
	Status of Applicant's Parents / Family (select all that apply): ☐ Active Parental / Family Involvement ☐ Parent / Family Uninvolved ☐ Applicant has a history of exploitation by Parent / Family ☐ Applicant does not want family involved ☐ Unknown ☐ Other: _____
	Status of Applicant's Offspring (select all that apply): ☐ Children ☐ No children ☐ Unknown ☐ Pregnant ☐ # of Male children: _____ ☐ # of Female children: _____ ☐ # of Custodial children: ____ ☐ Open Case with DHS? Provide DHS Contact Name & Phone #: _____

4. Family/Friend/Emergency contact(s): (Include name, telephone number and relationship)

Name:		Phone:		Relationship:	
Name:		Phone:		Relationship:	
Name:		Phone:		Relationship:	
Name:		Phone:		Relationship:	

Section C: Characteristics

1. Current Living Situation: (Check One) Where does the applicant live currently?

☐ State Hospital (NSH / other) ☐ Hospital – Psychiatric ☐ Hospital – Medical ☐ Hospital – detox or rehab ☐ Correctional Facility – Prison ☐ Correctional Facility – Jail ☐ LTSR ☐ MH Residence (other than LTSR) ☐ Nursing Home ☐ IDS / CLA ☐ Recovery House ☐ PCBH ☐ Family Home ☐ Independent Living ☐ Homeless / Shelter ☐ Unknown ☐ Other: _____

Facility Name (if applicable):_____

Address: _____

Length of occupancy (in months): _____

2. Previous Living Situation: (Check One) Where did the applicant live prior to their current living situation?

☐ State Hospital (NSH / other) ☐ Hospital – Psychiatric ☐ Hospital – Medical ☐ Hospital – detox or rehab ☐ Correctional Facility – Prison ☐ Correctional Facility – Jail ☐ LTSR ☐ MH Residence (other than LTSR) ☐ Nursing Home ☐ IDS / CLA ☐ Recovery House ☐ PCBH ☐ Family Home ☐ Independent Living ☐ Homeless / Shelter ☐ Unknown ☐ Other: _____

Facility Name (if applicable):_____

Address: _____

Length of occupancy (in months): _____

3. Has the applicant ever been homeless? ☐ Yes ☐ No

If you answered "Yes" to Question 3, complete the following. (Include dates of the most recent episode of homelessness, provide name of shelter, drop-in center, street, etc., under "Location." List the most recent locations first)

Date:		Location:	
Date:		Location:	
Date:		Location:	
Date:		Location:	

4.	Current Employment Status (check one): ☐ Competitive Employment ☐ Unknown ☐ No Employment of any kind ☐ Other: _____
5.	Income or benefits currently receiving: (check all that apply) ☐ Wages, salary or self-employed ☐ SSI ☐ SSDI ☐ Social Security Retirement, survivor's benefits ☐ Veteran's Benefits ☐ Worker's Compensation ☐ Medicare ☐ Medicaid ☐ Cash Assistance / Food Stamps ☐ Private Insurance ☐ Ineligible ☐ None ☐ Other: _____
6.	Do you have a representative payee? ☐ Yes ☐ No Representative Payee Name: _____ Representative Payee Contact Information: _____

Section D: Criminal Justice Involvement

1.	Criminal Justice Status (check all that apply):	
	☐ No criminal history	☐ No history of probation / parole
	☐ Under supervision of MH court	☐ Under supervision of probation / parole
	☐ State Incarceration	☐ County Detention
	☐ NSH - Building 51	☐ Megan's Law Registrant
2.	Any prior felony convictions? ☐ Yes ☐ No	

If "yes" to Question 2, list prior convictions:

Conviction (e.g. Aggravated Assault)	Year (e.g. 1999)

If “yes” to Question 2, what is the approximate total years held in detention / incarcerated? _____

Section E: Clinical

1. Clinical Disorders and other conditions that are a focus of clinical attention.

ICD 10/DSM-V Code	Diagnosis (if none, please indicate)

2. General Medical Conditions:

ICD 10 Code	Diagnosis

3. Life Stressors

ICD Definition of Code /DBHIDS Inclusion Criteria - Social Determinants of Health (SDOH)

☐	Inadequate housing	☐	Homelessness
☐	Lack of adequate food or safe drinking water	☐	Problem living in a residential institution
☐	Extreme poverty	☐	Victim of crime
☐	Target of (actual or perceived) adverse discrimination or persecution	☐	Imprisonment or other incarceration including arrest and/or conviction
☐	Academic or educational problem	☐	Social exclusion or rejection
☐	Insufficient social insurance or welfare support	☐	Disruption of family by separation or divorce
☐	Unavailability of inaccessibility of healthcare facilities	☐	Unavailability of inaccessibility of other helping agencies
☐	Personal history (past history) of abuse experienced in childhood - includes physical, sexual and neglect	☐	Personal history (past history) of experiencing violence perpetrated by spouse or partner - includes any history or current abuse that is physical, sexual or psychological in nature
☐	Discord with social service providers including probation officer, case manager or social services worker		

3. Current Psychotropic Medications: ☐ None prescribed

Name	Dosage	Schedule

4. Current Physical Medications: ☐ None prescribed

Name	Dosage	Schedule

5. Adherence to Medication Regimen: (check one)

☐	Takes Medications as prescribed	☐	Participant refuses medication
☐	Takes Medications as prescribed most of the time	☐	Medication not prescribed
☐	Sometimes takes medications	☐	Other:
☐	Rarely takes medications	☐	Unknown

6. List all allergies including drug allergies, environment, food, etc. ☐ No Known Allergies

_____

7. What level of support is required for compliance with medication regimen? (check one)

☐	Independent	☐	Reminders	☐	Supervision	☐	Dispensing	☐	N/A

8. Does the applicant have a medical condition that requires special services such as special medical equipment, medical supplies, ongoing physician support and / or a therapeutic diet? ☐Yes ☐No

If yes describe: _____

9. Name of PCP / Facility: _____ Phone: _____

10. Pharmacy: _____ Phone: _____

11. Medical Tests:

Has Applicant been tested for TB in the past year? ☐ Yes ☐ No ☐ Unknown

Result: ☐ Positive ☐ Negative

COVID Testing (most recent if multiple testing occurred)? ☐ Yes ☐ No
Date: _____ Result: ☐ Positive ☐ Negative

COVID Vaccination? ☐ Yes ☐ No Date (s): _____/_____

12.	Physical Functioning Level (Check all that apply): ☐Fully ambulatory ☐ Can climb one flight of stairs ☐ Can bathe self ☐ Can feed self ☐ Can dress self ☐ Needs help toileting

Section F: Utilization

1. Applicant Services within the last 12 months: (Check all that apply)

☐	None	☐	CRC
☐	State Psychiatric Hospital	☐	Detention / Jail / Prison
☐	Medical Hospital	☐	County Psychiatric Hospital
☐	Behavioral Health Residential Placement	☐	ACT / Blended Enhanced Services / CM
☐	Drug and Alcohol IOP	☐	Drug and Alcohol Inpatient Rehab
☐	Mental Health Outpatient Therapy	☐	Other:

2. Institutional Services utilization including current hospitalization if applicable. (Indicate the number of utilizations for each. Include “0” if none. “UNK” if unknown.)

	Psychiatric Hospitalizations in past 12 months		Psychiatric Hospitalizations - past 24 months
	CRC Visits in past 12 months		CRC Visits in past 24 months
	Arrests in past 12 months		Arrests past 24 months

3. List all psychiatric hospitalizations (including current) and CRC visits within the last two years (This information is required to determine eligibility for service).

Hospital / CRC	Admission / Contact Date	Discharge Date

4. Indicate any mental health or substance use programs the participant attends, had previously attended in the last 24 months, and/or if the program is part of the discharge plan.
Indicate whether program is: C = Currently attending or P = Previously attended

Type	Name	Status
Behavioral Health Program		
Substance Use Treatment		
Day Program		
Vocational Program		

Section G: Well Being

1. Co-occurring disabilities: (Check all that apply)

☐	None	☐	Impaired ability to walk	☐	Deaf
☐	TBI / Cognitive disorder	☐	Wheelchair required	☐	Amputee
☐	Visual Impairment	☐	Hearing Impairment	☐	Incontinence
☐	Blindness	☐	Speech Impairment	☐	Other:
☐	Intellectual Disability *Please indicate source of information regarding status of ID* _____				

2. Indicate the applicant's status regarding high risk behaviors. (Check one response for each).

High Risk Behaviors	0	1	2	3	4	5	U
Physical harm to self	☐	☐	☐	☐	☐	☐	☐
Suicide attempts	☐	☐	☐	☐	☐	☐	☐
Cutting / self-injury	☐	☐	☐	☐	☐	☐	☐
Physically abused another	☐	☐	☐	☐	☐	☐	☐
Assaulted another	☐	☐	☐	☐	☐	☐	☐
Was a victim of sexual abuse	☐	☐	☐	☐	☐	☐	☐
Was a victim of physical abuse	☐	☐	☐	☐	☐	☐	☐
Engaged in arson	☐	☐	☐	☐	☐	☐	☐
Engaged in accidental fire-setting	☐	☐	☐	☐	☐	☐	☐
Engaged in a Homicide attempt	☐	☐	☐	☐	☐	☐	☐
Had Delusions	☐	☐	☐	☐	☐	☐	☐
Experienced Hallucinations	☐	☐	☐	☐	☐	☐	☐
Engaged in Disruptive behavior	☐	☐	☐	☐	☐	☐	☐

0= no known history
1= not at all in the past 6 months
2= one or more times in the past 6 months, but not in the past 3 months

3= one or more times in the past 3 months but not in the past month
4= one or more times in the past month but not in the past week
5= one or more times in the past week
U= Unknown

3. Does the applicant have a history of substance use? ☐ Yes ☐ No

Indicate applicant's status in regard to substance use. (Check one response for each)

0=no known history
1=not at all in the past 6 months
2=one or more times in the past 6 months, but not in the past 3 months
3=one or more times in the past 3 months but not in the past month
4=one or more times in the past month but not in the past week
5=one or more times in the past week
6=daily
U=unknown

Substances	0	1	2	3	4	5	6	U
Alcohol	☐	☐	☐	☐	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐	☐	☐	☐	☐
Marijuana / Cannabis	☐	☐	☐	☐	☐	☐	☐	☐
Synthetic Marijuana (K2)	☐	☐	☐	☐	☐	☐	☐	☐
Heroin / Opiates / Opioids	☐	☐	☐	☐	☐	☐	☐	☐
Crack / Cocaine	☐	☐	☐	☐	☐	☐	☐	☐

PCP	☐	☐	☐	☐	☐	☐	☐	☐
Methamphetamines	☐	☐	☐	☐	☐	☐	☐	☐
Inhalants	☐	☐	☐	☐	☐	☐	☐	☐
Hallucinogens	☐	☐	☐	☐	☐	☐	☐	☐
Sedatives/hypnotics/anxiolytics	☐	☐	☐	☐	☐	☐	☐	☐
Other prescription drug abuse	☐	☐	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐	☐	☐