Cornerstone Montgomery

**ASSERTIVE COMMUNITY TREATMENT (ACT)**

**REFERRAL FORM**

Date of Application: _____/_____/_____

## Service Definition

Assertive Community Treatment (ACT) is an intensive, integrated, rehabilitative, treatment and community-based service provided by an interdisciplinary team to adults with serious and persistent mental illness. ACT services are provided to consumers in accordance with the IRP. ACT teams involve specific and dedicated staff and specific staff to consumer ratios. Service coverage by the ACT team is required to have specific programs hours but to be available for crisis services 24 hours per day, seven days per week.

## Insurance Requirements

- **Medicaid**
- **Medicare and Medicaid**
- **Uninsured:** Consumers must qualify Uninsured Eligibility Span- see page 6 for requirements
- **Medicare only:** Consumers must qualify Uninsured Eligibility Span- see page 6 for requirements

**Referral Requirements: Please include the following documents in application: Referral Form, Psychosocial summary, and a documented diagnosis from a behavioral health provider.**

## I. Referral Source Information From a mental health or homeless service provider

**Referring Agency Name & Contact:**_____

**Referral Source Phone:** _____

**Referral source e-mail :** _____

**Hospital referrals': Please include the admission summary, discharge summary and current medication list.**

## II. Consumer Demographic Information

**Consumer Name: _____**

**Aliases:_____**

**DOB: _____**

**SSN : _____**

**HMIS # if known : _____**

**Current Address/Shelter: _____**

**Other Locations the Consumer frequents: _____**

**Consumer Phone #: _____**

## III. Linkage Information

**Last time seen by Referring Agent/Frequency of Contact_____**

**Other providers/individuals who can be contacted to reach consumer for intake:**

_____

_____

_____

**Name and Phone # of legal guardian if applicable_____**

## IV. ACT Admission Criteria:

***Criteria A:*** **The consumer has a PMHS specialty mental health DSM diagnosis included in the priority population (see page 6), which is the cause of significant psychological, personal care, and social impairment.**

**Diagnosis & symptoms experienced:**

_____

_____

_____

_____

_____

_____

***Criteria B:*** **Use of emergency services due to psychiatric symptoms. Please check which of the following apply and provide details. At least one of the below criteria must be met:**

**____ Frequent use of emergency rooms for psychiatric reasons (two or more a year):**

_____

_____

_____

**____ Psychiatric hospitalizations (two or more a year and has experienced in last year):**

_____

_____

_____

**____ Arrests/ incarcerations for reasons associated with the individual's mental illness:**

_____

_____

_____

***Criteria C:*** **The impairments result in at least one of the following. Please check which of the following apply and provide details- at least one criteria must be met:**

**_____ A clear, current threat to the individual's ability to live in their customary setting, or the individual is homeless, and would need a higher level of care if ACT services were not provided:**

_____

_____

_____

**_____ An emerging/ impending risk to self and/or others:**

_____

_____

_____

**_____ Documented inability to sustain involvement with or remain engaged in traditional office-based services (including outpatient behavioral health clinics, PRP, and/ or RRP) :**

_____

_____

_____

***Criteria D:***

**Further evidence of clinical, life crises, and impact on Activities of Daily Living. Please check which of the following apply and provide details.**

**___ Consumer is currently experiencing homelessness, has a history of chronic homelessness, or is vulnerable to homelessness: _____**

_____

_____

**___ Consumer is unemployed, has demonstrated markedly limited job skills, or has little work history: _____**

_____

**___ Consumer displays deficits in cognitive organization, demonstrates an inability to maintain a personal support system, or exhibits inappropriate social behaviors:**

_____

_____

**___ Consumer's present needs are not being adequately met by a coordinated system of care: _____**

_____

## V. Psychosocial Summary - Please Attach.

**I understand that I will be assessed for Cornerstone Montgomery's ACT team and if eligible for services I will be placed on the waiting list. I can contact Value Options at 1-800-888- 1965 if I am in urgent need of services. I hereby grant permission for my therapist /prescriber to provide Cornerstone Montgomery, Inc with my diagnosis and any other referral documentation that is requested.**

_____ _____

Applicant Signature Date

_____ _____

Referral Source Signature Date

## Fax completed application to: 888-525-4231

## Uninsured "Eligible Uninsured" Consumers

All of the following conditions must be met in order to receive services with an Uninsured Eligibility Span:

**Requirements**:

- The consumer requires treatment for a mental health diagnosis(es) covered by the PMHS
- The consumer has a verifiable Social Security Number
- The consumer has applied for Medical Assistance (MA), EID, Supplemental Security Income (SSI), or Social Security Disability Insurance (SSDI). If the consumer is not eligible for MA, SSI, or SSDI, documentation from MA or Social Security stating the reason for ineligibility must be provided and maintained in the consumer's medical record.
- The consumer is a Maryland Resident (permanent address or homeless)
- The consumer meets the financial criteria (250% of federal poverty level). (The service provider is responsible for collecting and maintaining documentation from the consumer that validates the consumer's financial need. This may include documentation of application and outcome for benefits, pay stubs, other income, etc. to document that the consumer meets the financial criteria),

**AND**

**Criteria**: The consumer must meet ONE of the following:

- The consumer has received services in the PMHS in the past two years,
- The consumer is currently receiving SSDI for mental health reasons, • The consumer is homeless within the state of Maryland,
- The consumer was released from prison, jail or a Department of Correction facility within the last 3 months,
- The consumer was discharged from a Maryland-based psychiatric hospital within the last 3 months,
- The consumer is receiving services as required by an order of a Conditional Release; or
- The consumer has an urgent need for outpatient mental health services and has been approved by the Core Service Agency (CSA).
- The consumer is a veteran

**PRIORITY POPULATION DIAGNOSES**

| ICD-10 CODE | DSM-5 Diagnosis |
|---|---|
| F20.81 | Schizophreniform D/O |
| F25.0 | Schizoaffective D/O, Bipolar Type |
| F25.1 | Schizoaffective D/O, Depressive Type |
| F20.9 | Schizophrenia |
| F22 | Delusional D/O |
| F28 | Other Specified Schizophrenia Spectrum and Other Psychotic D/O |
| F29 | Unspecified Schizophrenia Spectrum and Other Psychotic D/O |
| F33.2 | Major Depressive D/O, Recurrent Episode, Severe w/o Psychotic Features |
| F33.3 | Major Depressive D/O, Recurrent Episode, Severe w/ Psychotic Features |
| F31.0 | Bipolar I D/O, Current or MRE, Hypomanic |
| F31.9 | Bipolar I D/O, Current or MRE, Hypomanic, Unspecified |
| F31.13 | Bipolar I D/O, Current or MRE, Manic, Severe w/o Psychotic Features |
| F31.2 | Bipolar I D/O, Current or MRE, Manic, Severe w/ Psychotic Features |
| F31.4 | Bipolar I D/O, Current or MRE, Depressed, Severe w/o Psychotic Features |
| F31.5 | Bipolar I D/O, Current or MRE, Depressed, Severe w/ Psychotic Features |
| F31.9 | Bipolar I D/O, Current or MRE, Unspecified |
| F31.81 | Bipolar II D/O |
| F21 | Schizotypal Personality D/O |
| F60.3 | Borderline Personality D/O |