OREGON HEALTH AUTHORITY

Participant name:	Date of birth:
Prime number (if applicable):	

Assertive Community Treatment (ACT) Universal Referral Form

Date: _____

Name and job title of person referring: _____

Contact information for referring agency: _____

Type of request:

◯ **New Referral**: Is there additional/supplimental documents included with referral? ◯ Yes ◯ No. If yes, explain:

_____

◯ **Transfer**: Provide previous ACT Program contact information:

_____

Individual's Information

Current location: _____

Phone number (if applicable): _____

Address or expected address: _____

County where they plan to live: _____

Gender identity: _____

Culture: _____

If enrolled Tribal member, name of Tribe: _____

Preferred language: _____

Guardian's name: _____

Guardian's preferred method of contact _____

If no guardian, is there an emergency contact for the individual?: ◯ Yes ◯ No

Emergency contact's phone number (if applicable): _____

Type of health insurance or coordinated care organization type:

_____

Primary mental health diagnosis: _____

Most recent mental health assessment: _____

Who completed the mental health assessment?: _____

Is the individual part of Aid and Assist? ◯ Yes ◯ No

Anticipated discharge date: _____

Note: To qualify for ACT services, a person must have a primary diagnosis of a serious and persistent mental health condition and have needs that affect their daily functioning. More information is available in OAR 309-019-0245 https://oregon.public.law/rules/oar_309-019-0245

1. Does the individual struggle with reasoning or critical thinking that have caused negative consequences in their daily life in at least one of the areas below?

   - ☐ Taking care of their bills,
   - ☐ Getting help with doctors, legal problems, or housing,
   - ☐ Staying safe,
   - ☐ Getting enough food,
   - ☐ Personal hygiene,
   - ☐ Making meals,
   - ☐ Washing clothes,

- ☐ Taking care of children,
- ☐ Keeping a steady job.

  Briefly explain:

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2. Does the client have another condition that also contributes to negative consequences?

Substance use disorder(s): ◯ No ◯ Yes. If yes, please list disorder(s):

Other disorder(s): ◯ No ◯ Yes. If yes, please list disorder(s):

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3. Does the client show one or more of the following signs of ongoing high service needs? Check all that apply:
   - ☐ Goes to a mental health hospital two or more times per year or for emergency services for mental health.
   - ☐ Has ongoing major mental health needs, such as depression psychosis, or thoughts of self-harm.
   - ☐ Has been arrested or involed with the police or courts recently.
   - ☐ Lives in a supervised community home, but could live more independently with intensive support services.
   - ☐ Has difficulty with regular in-office mental health appointments.

Additional notes

Include other services the client uses or anything that will help us learn about them. Helpful information such as; medications, allergies, triggers, etc

ACT program (or Single Point Of Contact) determination

Referral review date: _____

◯ Accepted for next-step of review:

- ACT team member point of contact: _____
- Met criteria but placed on waitlist.
  Check status via: _____

◯ Pending (list items needed and deadline to return):

_____

◯ Denied: See attached letter

_____ _____

Signature of ACT Services **Date**

(Whomever made the 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 amh.web@state.or.us or call 1-844-882-7889 (voice). We accept all relay calls.

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