



Empowering People.
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ACT SCREENING TOOL

Date of Referral:

Referral Source:

Referent's Phone #:

Client Name:

Date of Birth:

Soc. Sec. #:

Medical Assistance # (must have active MA to qualify for ACT):

County of residence:

Client's Phone #:

Client's primary language (is an interpreter needed?):

Diagnosis: (include description/code; indicate primary / secondary)

	Code: _____ <input type="checkbox"/> 1° <input type="checkbox"/> 2°
	Code: _____ <input type="checkbox"/> 1° <input type="checkbox"/> 2°
	Code: _____ <input type="checkbox"/> 1° <input type="checkbox"/> 2°
	Code: _____ <input type="checkbox"/> 1° <input type="checkbox"/> 2°

WHODAS: _____

Additional Assessments completed:

Current Service Providers:

Name	Agency	Phone
Psychiatrist:		
Therapist:		
Case Manager:		
Other (specify):		
Other (specify):		

Current Medications: _____



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Current Living Situation (*with address*): _____

Current Sources of Income: _____

Is the client under Civil Commitment? No Yes
If yes: Date: _____ Status: _____

NTP/Jarvis? No Yes Price Sheppard? No Yes

Priority will be given to individuals who meet one of the following criteria. Check all that apply:

The person has been recently discharged from an extended stay in a state hospital (e.g., 3 months or more). **Name of facility:** _____
Length of Stay: _____ months

High utilization of acute psychiatric hospitals (e.g., 2 or more admissions per year). **Specify # of admissions over the past 2 years:** _____
Admit & Discharge Dates: _____

High utilization of psychiatric emergency services (e.g., 6 or more per year). **Specify type & approximate # of admissions:** _____ # ER _____ # Crisis Stabilization _____
Detox

Additional considerations for ACT service - Check all that apply:

Co-existing substance use disorder (indicate diagnosis above) of significant duration (e.g., greater than 6 months). **Duration:** _____ months. **What is client's stage of substance abuse treatment?** _____

Client poses a risk of harm to (*check all that apply*): Self Others
Explain: _____



Exhibits socially disruptive behavior with high risk of criminal justice involvement (e.g., arrest and incarceration). **In the past two years, the person has (check all that apply):**

- Had multiple arrests
- Been incarcerated
- Had numerous contacts with law enforcement (# if known) _____

Describe legal history: _____

Describe history of aggression (verbal, physical, threats, etc.): _____

Residing in a supervised residence, but assessed to be appropriate for a more independent setting with ACT Services such as -- **specify type:**

- Corporate Foster Care
- Assisted Living
- Family Foster Care
- Board & Lodge
- Rule 36

Risk of placement in a supervised community residence, can remain independent if intensive services are provided. **Specify Type:**

- Corporate Foster Care
- Family Foster Care
- Assisted Living
- Board & Lodge

Persistent and recurrent difficulty performing practical tasks of daily living (**check all that apply**):

- Managing personal business affairs
- Obtaining medical or legal services
- Recognizing and avoiding common dangers
- Meeting nutritional needs
- Maintaining personal hygiene
- Benefit/income management
- Medication adherence
- Accessing community resources/social support systems

Persistent or recurrent difficulty performing practical tasks of daily living (as listed in the preceding question) without significant assistance from others (friends, family or relatives).

The individual is residing in substandard housing, is homeless, or at imminent risk of becoming homeless. **Specify:** _____



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To Be Completed By ACT Team

Client will be opened with ACT Team, services are medically necessary

Client will not be opened with ACT services. Reason:

Mental Health Professional's Name: _____

Date: _____

Signature: _____