



Merakey Pennsylvania ACT Referral Packet

As defined in the Office of Mental Health and Substance Abuse Services Bulletin (OMHSAS), Assertive Community Treatment (ACT) is a consumer-centered, recovery-oriented, mental health service delivery model that has received substantial empirical support for facilitating community living, psychosocial rehabilitation, are recovery for persons with the most serious mental illnesses and impairments who have not benefited from traditional outpatient programs.

Referrals to Merakey ACT Teams will be submitted by hospitals, jails/prisons, Long Term Structured Residences (LTSR), case management providers, Counties, Payers and other similar professional agencies supporting the individual identified as needing services. Please note that due to the intense level of treatment provided by ACT Teams, referrals not from a professional agency are not able to be accepted.

The attached packet will be completed in full by the referral source in collaboration with the consumer and provided to the ACT Team Leader, along with a psychiatric evaluation completed within the last 12 months. Any sections of the referral packet that are not relevant to the individual, please note N/A. Please note that referrals will not be reviewed for acceptance into the program until a completed referral is received.

The referral source will be contacted within 3 business days of the Team Leader receiving the completed referral with either disposition or additional questions. An intake assessment will be scheduled within 5 business days of the decision and notification of acceptance. Should the individual be determined appropriate for the program, an intake date will be set up. If the individual does not meet program criteria, the referral source will be notified by call and receive written notification for their records.

Required Documents

- ☐ Completed Referral Packet
- ☐ Psychiatric Evaluation (within previous 12months)
- ☐ Current Medication List
- ☐ Current Diagnosis Documentation
- ☐ Recent Psychiatric Hospital Records (if applicable)
- ☐ Current Treatment Plan (ifavailable)
- ☐ Release of Information Forms
- ☐ Insurance Verification
- ☐ Guardianship/POA Documentation (ifapplicable)
- ☐ Legal Documentation (probation/parole/court orders if applicable)



Referral Date: _____

ACT/FACT CRITERIA FOR ELIGIBILITY

Individual Name: _____

DOB: _____

NECESSARY CRITERIA-MUST MEET BOTH 1 AND 2

- ____1. Age 18 or older
- ____2. Has a serious diagnosis of mental illness (SMI): **Primary diagnosis of** ☐schizophrenia, ☐bipolar disorder, ☐schizoaffective disorder or ☐other psychotic disorders
Primary diagnoses of SUD, Intellectual Disability, or Brain Injury alone are not considered the intended ACT population.

MUST HAVE AT LEAST TWO (2) OF THE FOLLOWING CRITERIA

- ____3. At least two (2) psychiatric hospitalizations in the past 12 months
- ____4. More than 30 inpatient psychiatric days in the past 12 months
- ____5. Persistent psychotic, affective, or suicidal symptoms
- ____6. Co-occurring mental illness and substance use disorders
- ____7. Criminal justice involvement, which may include frequent contact with law enforcement personnel, incarcerations, parole or probation.
- ____8. Homelessness or risk of homelessness
- ____9. Need for intensive support to avoid institutional care
- ____10. Residing in a supervised community residence but clinically assessed to be able to live in a more independent living situation if intensive services are provided or requiring residential placement if more intensive services are not available.

MUST MEET THE FOLLOWING - Functional Impairment

- ____11. The individual demonstrates serious and persistent mental illness resulting in significant functional impairment and inability to successfully engage in traditional outpatient treatment
- ____12. Current/Prior Global Functional Impairment Evidence (score of 40 or below): _____

_____ This referral is being submitted under Pennsylvania ACT exception criteria. Please note that ACT teams may only maintain up to 10% of their total caseload under exception criteria, and acceptance is contingent upon current exception capacity and program approval.

ROI Obtained for Referral? ☐ Yes ☐ No

Referral Source Relationship to Consumer

☐ Hospital ☐ County Program ☐ Case Management ☐ Outpatient Provider ☐ Criminal Justice ☐ Residential Program
☐ Other: _____

Consumer Signature: _____ Date _____

Referral Source Signature: _____ Date _____

Contact Person and Role: _____

Contact Phone: _____ Email: _____



Consumer Information

Name (Last, First, Middle): _____

Maiden Name/Aliases: _____

DOB: _____ Social Security Number: _____ County of Residence: _____

Address: _____

Primary Telephone Number: _____ Home or Cellphone

Preferred Contact Method: ☐ Call ☐ Text ☐ Email ☐ Through Provider

Veteran Status ☐

Gender: _____ Marital Status: _____

Primary Language Spoken: _____

Translation Services needed: _____

If yes, Language needed: _____

Behavioral Health Managed Care Organization:

☐ Community Care

Member ID: _____

☐ PerformCare

☐ Carelon

☐ Other: _____

Current Living Situation

☐ Own Apartment/Home

☐ Family Residence

☐ Personal Care Home

☐ CRR Host Home

☐ Shelter

☐ Homeless

☐ Hotel/Motel

☐ Inpatient Facility

☐ Jail/Prison

☐ Other: _____

Identifying Information

Hair Color _____

Eye Color _____

Weight _____

Height _____

Emergency Contact

Name: _____

Address: _____

Telephone Number: _____ Home or Cell

Relationship with Consumer: _____

Family/Natural Supports Involved in Treatment

Name	Relationship	Contact Information	Involved in Treatment	ROI Signed?

Consumer's Preference Regarding Family Involvement: ☐ Wants active family involvement
☐ Limited family involvement
☐ No family involvement requested
☐ No natural supports identified

Consumer's Strengths and Interests

Consumers Strength	Consumers Interests
Check all that apply and add narrative. ☐ Motivated for treatment ☐ Medication adherence ☐ Independent living skills ☐ Family support ☐ Employment history ☐ Educational strengths ☐ Good communication skills ☐ Community involvement ☐ Positive coping skills ☐ Recovery-oriented goals ☐ Other: _____	☐ Music ☐ Art ☐ Sports ☐ Exercise ☐ Reading ☐ Faith/Spirituality ☐ Volunteering ☐ Employment ☐ Education ☐ Pets ☐ Technology ☐ Community Events ☐ Other: _____

Informal Community Supports

- ☐ Family
- ☐ Friends
- ☐ Neighbors
- ☐ Faith Community
- ☐ Club/Organization Membership
- ☐ Recovery Community
- ☐ Volunteer Activity
- ☐ Other: _____

Current Community Supports

Support Type	Provider/Agency	Service Provided	Active?
Psychiatrist			☐ Yes ☐ No
Therapist (MH)			☐ Yes ☐ No
Therapist (D/A)		☐ IOP ☐ Group ☐ Individual Sessions	☐ Yes ☐ No
Case Manager		☐ Blended ☐ Drug and Alcohol ☐ Intensive ☐ Administrative	☐ Yes ☐ No
Peer Support			☐ Yes ☐ No
Supported Housing			☐ Yes ☐ No
Vocational Program			☐ Yes ☐ No
Religious/Spiritual Support			☐ Yes ☐ No
Family Based Services			☐ Yes ☐ No
Other			☐ Yes ☐ No

Presenting Problem (Include Consumer's Perspective):

Describe the current symptoms, functional limitations, barriers to recovery, and circumstances leading to this referral.

Why is ACT/FACT Being Requested?

Describe why traditional outpatient treatment, case management, or other community services have been insufficient to meet the consumer's needs. Include specific examples of psychiatric instability, hospitalization, homelessness, criminal justice involvement, treatment nonadherence, or inability to engage in office-based services.



Current DSM-5 Diagnosis including ICD-10 codes:

ICD-10 Code	DSM-5 Diagnosis	Primary Diagnosis
		☐ Yes
		☐ No
		☐ No
		☐ No
		☐ No

Most Recent Psychiatric Evaluation Date: _____

HOSPITALIZATION HISTORY

Current Hospitalization Status

Is the Consumer currently hospitalized? ☐ Yes ☐ No

If yes, complete the following:

Current Hospital/Facility: _____ Unit/Program: _____

Social Worker/Discharge Planner: _____ Telephone: _____

Email: _____

Date of Admission: _____ Projected Discharge Date: _____

Current Commitment Status:

☐ Voluntary (201)

☐ Involuntary (302)

☐ Other: _____

Psychiatric Hospitalizations within the last 12 months

Hospital/Facility	Admission & Discharge	Commitment Type (201/302/Other)	Reason for Admission



Additional Crisis Services Utilized Within Previous 12 Months

Is the Consumer currently on an outpatient commitment? ☐ yes ☐ no

Effective Date: _____ Expiration Date: _____

Will an outpatient commitment be part of their current discharge plan? ☐ yes ☐ no

MEDICATIONS

Is the Consumer able to identify and manage their medications independently? ☐ yes ☐ no

Consumer Pharmacy: _____

Current Medications ☐ Check if medication list is attached with all requested information

Medication Adherence

Check all that apply:

- ☐ Independently manages medications
- ☐ Requires reminders
- ☐ Family/support assists with medications
- ☐ Visiting nurse assists with medications
- ☐ History of nonadherence with medication
- ☐ Frequently misses doses
- ☐ Refuses medications
- ☐ Difficulty obtaining medications
- ☐ Cognitive barriers to medication management
- ☐ Other: _____

Is the Consumer on any long-acting injectable (LAI) medications? ☐ yes ☐ no

If yes, where do they currently go to receive the injection? _____

Frequency: _____

Is the Consumer being treated with Clozaril? ☐ yes ☐ no

If yes, please provide the follow questions:

When did they begin taking Clozaril? _____

How often are labs required? _____

Where are labs drawn? _____

Any irregular labs received? ☐ yes ☐ no If yes, when _____

Over the Counter Medications (including vitamins and as needed)

Medication	Dose	Frequency	Purpose

**Medication Allergies**

Medication	Reaction

MEDICAL HISTORY

Provider Type	Provider/Practice	Contact Person	Phone Number
PCP			
Dentist			
Ob/Gyn (if applicable)			
Neurologist			
Optometrist			
Specialist			
Specialist			
Specialist			

Medical Conditions

Does the Consumer have any significant medical conditions? ☐ Yes ☐ No Check all that apply:

- ☐ Diabetes
- ☐ Hypertension
- ☐ COPD
- ☐ Asthma
- ☐ Seizure Disorder
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Heart Disease
- ☐ Obesity
- ☐ Chronic Pain
- ☐ Traumatic Brain Injury
- ☐ Mobility Limitations
- ☐ Other: _____

Medical Equipment and Supports

Check all that apply:

- ☐ Cane
- ☐ Walker
- ☐ Wheelchair
- ☐ Oxygen
- ☐ CPAP/BiPAP
- ☐ Hearing Aid
- ☐ Glasses
- ☐ Prosthetic Device
- ☐ Other: _____

Medical Hospitalizations within the last 12 months

Hospital	Admit Date	Reason	New or Existing Condition	Follow-Up Required



SUBSTANCE USE HISTORY

Does the Consumer have a history of substance use? ☐ yes ☐ no

If no, this section does not need completed.

Substance	Frequency of Use	Method of Use	Age of first Use	Date of Last Use	Consumer identifies Use as Problematic
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

Current Substance Use Status

Check all that apply:

- ☐ Active Use
- ☐ Early Remission
- ☐ Sustained Remission
- ☐ Medication-Assisted Recovery
- ☐ Recovery Support Participation
- ☐ Denies Current Substance Use
- ☐ History of Overdose
- ☐ History of Withdrawal Symptoms
- ☐ History of Substance-Induced Psychosis
- ☐ Tobacco/Nicotine Use
- ☐ Cannabis Use

MEDICATION-ASSISTED TREATMENT (MAT)

Is the Consumer currently receiving medically assisted treatment (MAT)? ☐ yes ☐ no

MAT Adherence

- ☐ Consistently Engaged
- ☐ Intermittently Engaged
- ☐ Recently Started
- ☐ Missed Doses/Appointments

Has the Consumer ever engaged in drug and alcohol treatment? ☐ yes ☐ no

If yes, provide brief treatment history information below

Treatment Facility	Dates of Treatment	Voluntary or Court Ordered	Residential, IOP, or Outpatient	Completed (yes/no)
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No



LEGAL INVOLVEMENT

Is the Consumer have currently involved with the criminal justice system? ☐ yes ☐ no

If yes, complete the following section:

Current Legal Involvement

Current Charge	Current Status/Disposition	Follow up Required

Provide All Upcoming Court Hearing Dates and Times:

Court Date	Time	Court/County	Purpose

Attorney Name: _____

☐ Public Defender

☐ Private Attorney

Phone Number: _____

☐ **Email:** _____

Probation / Parole Information

Currently on Probation or Parole? ☐ Yes ☐ No

Officer Name: _____

Phone Number: _____

Email: _____

Megan's Law Information

Megan's Law Registration Required? ☐ Yes ☐ No

If yes:

☐ Tier I

☐ Tier II

☐ Tier III

☐ Pre-SORNA SVP

Reporting requirements: _____

Conditions and Requirements

Check all that apply:

☐ Reporting Requirements

☐ Drug and Alcohol Treatment

☐ Mental Health Treatment

☐ Medication Compliance

☐ Curfew

☐ Employment Requirement

☐ Housing Requirement

☐ Community Service

☐ Electronic Monitoring

☐ Other: _____

**Past Legal History**

Check all that apply:

Violent Offenses

- ☐ Aggravated Assault
- ☐ Simple Assault
- ☐ Domestic Violence
- ☐ Reckless Endangerment
- ☐ Kidnapping

Property Crimes

- ☐ Theft
- ☐ Burglary
- ☐ Arson
- ☐ Fraud

Drug-Related Offenses

- ☐ Drug Possession
- ☐ Drug Distribution

Other Offenses

- ☐ Sexual Offense
- ☐ Fleeing/Eluding
- ☐ Weapons Offense
- ☐ Other: _____

Number of times incarcerated: _____

FINANCIAL INFORMATION

Does the consumer independently manage their finances? _____ Yes _____ No

Representative Payee

Does the consumer have a Representative Payee? _____ Yes _____ No

☐ If yes:

Payee Name: _____

Agency/Relationship to Consumer: _____ Phone Number: _____

Email (if available): _____

Payee Required by Psychiatrist/Court Order? _____ Yes _____ No

Sources of Income

Check all that apply:

- ☐ SSI
- ☐ SSDI
- ☐ Employment Income
- ☐ Spouse/Partner Income
- ☐ Survivor Benefits
- ☐ Veterans' Benefits
- ☐ Pension/Retirement Income
- ☐ Unemployment Benefits
- ☐ Public Assistance
- ☐ Trust Fund
- ☐ Other: _____

Monthly Income Information

Total Monthly Income: \$ _____

Estimated Monthly Expenses: \$ _____

Source of Financial Support if No Income: _____



Legal Guardian

Does the consumer have a Legal Guardian? ☐ Yes ☐ No

If yes:

Guardian Name: _____

Agency/Relationship: _____

Phone Number: _____

Email: _____

Date Guardianship Became Effective: _____

Guardianship Authority Covers:

- ☐ Medical Decisions
- ☐ Psychiatric Treatment
- ☐ Financial Decisions
- ☐ Housing Decisions
- ☐ Full Guardianship
- ☐ Limited Guardianship
- ☐ Other: _____

A copy of Guardianship documentation must be supplied with referral.

Does the individual have a Power of Attorney? _____ Yes _____ No

☐ Yes ☐ No

If yes:

Type of POA

- ☐ Medical
- ☐ Financial
- ☐ Durable
- ☐ Limited
- ☐ Other: _____

Contact Information

Name: _____

Relationship/Agency: _____

Phone Number: _____

Email: _____

Effective Date: _____

Expiration Date (if applicable): _____

A copy of Power of Attorney documentation must be supplied with referral.