**10/28/2013 SOUTH DAKOTA DIVISION OF BEHAVIORAL HEALTH**

***Assertive Community Treatment Program***

REFERRAL FORM for:

- ◯ Behavior Management Systems (Rapid City)
- ◯ Community Counseling Services (Huron)
- ◯ Lewis and Clark Behavioral Health Services (Yankton)
- ◯ Southeastern Behavioral HealthCare (Sioux Falls)
- ◯ Capital Area Counseling Services (Pierre)
- ◯ Northeastern Mental Health Center (Aberdeen)

**Please mail with this form:**

- ☐ **History and Physical Examination**
- ☐ **Psychiatric Evaluation**
- ☐ **Updated Social History**
- ☐ **Current Treatment Plan**
- ☐ **Psychiatrist Progress Notes**
- ☐ **30 Days of Clinical Progress Notes**

Applicant Name _____

DOB _____

Gender ◯ M ◯ F

Last 4 digits of Social Security Number _____

First 2 letters of Mother's First Name _____

Receiving Medicaid (SSI) ◯ Yes ◯ No

Applicant's Address _____
Address

_____ _____ _____
City State Zip Code

Person Referring _____

Referring Agency _____

Phone _____

Email _____

**PLEASE DESCRIBE HOW THE INDIVIDUAL MEETS THE ELIGIBILTY CRITERIA FOR IMPACT IN THE SPECIFIC AREA LISTED. BE SPECIFIC!**

Is there any other appropriate community-based mental health services available to the individual? ◯ Yes ◯ No
If yes, they must be attempted / exhausted prior to ACT referral.
If no, list liaisons with whom you have discussed this referral.

Has CMHC CARE services in catchment area of IMPACT been contacted and indicated inability to provide needed services? ◯ Yes ◯ No
If yes, please list the person contacted from CMHC and reason given for denial.

If no, please contact CARE coordinator prior to submitting IMPACT referral.

**SMI Eligibility:** The individual meets criteria for a severe mental illness. The individual's severe emotional, behavioral, or psychological disorder caused him/ her to:

**(Must meet one of the four criteria – but check all that apply)**

☐ The individual has undergone psychiatric treatment more intensive than outpatient care and more than once in a lifetime, such as, emergency services, alternative residential living and inpatient psychiatric hospitalization.

☐ The individual has experienced a single episode of psychiatric hospitalization with an Axis I or Axis II diagnosis.

☐ The individual has been treated with psychiatric medication for at least one year.

☐ The individual has frequent crisis contact with a community mental health center or another mental health provider for more than six months as a result of a mental illness.

**And** this severe emotional, behavioral, or psychological disorder causes him/her to: **(The individual must meet at least three of the following criteria- please check all that pertain)**

☐ Be unemployed or have markedly limited job skills or have a poor work history.

☐ Exhibits inappropriate social behavior which results in concern by the community or requires mental health or legal intervention.

☐ Be unable to procure public assistance without assistance.

☐ Requires public financial assistance for out-of-hospital maintenance or difficulty in budgeting public financial assistance, or require on-going training in budgeting skills, or need a representative payee.

☐ Lack social support systems in a natural environment, such as close friends or family has caused the individual to live alone or be isolated.

☐ Be unable to perform basic daily living skills without assistance

The individual must meet at least **4** of the following criteria to demonstrate need for **IMPACT Services.** Please use narrative area to describe.

☐ The individual has persistent or recurrent difficulties performing daily living tasks unless significant support or assistance is available from others (friends/family or community mental health providers).

☐ Frequent Psychiatric hospitalizations in the past year.

☐ Constant or cyclical turmoil with family, social, or legal systems or inability to integrate into the community.

☐ Is currently residing in an inpatient, jail, prison or other residential facility but clinically assessed to be able to live more independently if intensive services were provided.

☐ Imminent threat of becoming homeless or losing housing.

☐ Likely to need residential or institutional placement if more intensive community services are not provided.

The individual has an Axis I DSM-IV-R diagnosis of a major mental illness. Note all diagnoses**:**

**Axis I**

**Axis II**

**Axis III**

The individual understands the ACT concept of involving professionals as well as natural supports in treatment and is willing to sign releases of information for the inclusion of these parties; and to obtain pertinent historical information.

◯ Yes ◯ No

Describe the individual's interpretation of ACT/IMPACT services and how the Team will engage them in the process**:**

What is the individual's current legal status? Is the individual under involuntary commitment for mental illness? Will this involuntary commitment continue when discharged from the hospitalization? Forced medication? Is there any other pending legal action?

Discuss past referrals/ placements and outcomes:

List the individual's strengths:

What family, social supports and financial assistance does the applicant have?

Describe the individual's living arrangements in the past 12 months:

Explain what needs to happen for this individual to live successfully in the community. Be specific. What does the individual need to do? What services will be needed? What has been lacking in previous community placements?

Describe any complex/co-occurring needs that may require integrated services for the individual to be successful in the community:

Discuss and give dates of severe and any recent critical incidents in the past six months. This should include verbal threats, physical aggression, command hallucinations to harm and criminal acts:

The treating psychiatrist or clinical supervisor (in accordance with the definitions section of ARSD:46:20:18:01(4) A Clinical Supervisor is a mental health professional who has at least a master's degree in psychology, social work, counseling or nursing, is licensed in their field, and has two years of supervised postgraduate clinical experience in a mental health setting) must sign below indicating the individual has medical need for services from an Assertive Community Treatment Program.

_____ _____

Psychiatrist/Clinical Supervisor Date Team Leader/CM/Therapist Date

**Please mail this form, history and physical examination, psychiatric evaluation (if available), a social history and all updates, a current treatment plan, psychiatric progress notes, past 30 days of daily progress notes, and other pertinent information as deemed appropriate to:**

SD Department of Social Services
Division of Behavioral Health
Kneip Building
c/o 700 Governor's Drive
Pierre, SD 57501
605-773-3123