OREGON HEALTH AUTHORITY
Assertive Community Treatment (ACT) Universal Tracking Form

Name of person who is completing this form: **Date:**
Patient Name: **DOB:**
County of Residence:
County in which the patient will be living & receiving ACT services:
CCO: **Medicaid ID number (if applicable):**
Is the patient currently under the jurisdiction of an Aid & Assist Order?
☐ Yes ☐ No

Referral Source:

Referral To:

Was a Clinical Assessment Completed? ☐ Yes ☐ No
If yes, provide the name and contact information of the clinician who conducted the assessment:

OSH Only

Patient Agrees to Referral for ACT Services: ☐

Patient Refuses Referral for ACT Services: ☐

If patient refuses, describe plan to address patient concern(s) regarding ACT Services:

Assertive Community Treatment (ACT) is a specialized model of treatment and service delivery designed to provide comprehensive community-based mental health services to persons with serious and persistent mental illness (SPMI) who are at least 18 years of age, have severe functional impairments, and who have not responded to traditional psychiatric outpatient treatment or less intensive non-standard levels of outpatient mental health treatment. Services are available to individuals with SPMI who have had a history of multiple psychiatric hospitalizations and/or crisis interventions. ACT services are provided over an extended period of time and include clinical, rehabilitation, recovery, supportive and case management services provided directly by a multidisciplinary team in the individual's natural environment. ACT serves as the primary provider of services and is in some cases available 24 hours a day, 7 days a week.

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Thin: Do Not Thin
OSH STK: XXXXX

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Is the client 18 years of age or older? ☐ Yes ☐ No

1. Clients diagnosed with severe and persistent mental illness as listed in the Diagnostic and Statistical Manual, Fifth Edition (DSM V) of the American Psychiatric Association that seriously impair their functioning in community living. Priority is given to people with schizophrenia, other psychotic disorders (e.g., schizoaffective disorder), and bipolar disorder because these illnesses more often cause long-term psychiatric disability.

   Is client diagnosed with a severe and persistent mental illness that seriously impairs their function in the community? ☐ Yes ☐ No

   Primary diagnosis:

2. Clients with other psychiatric illnesses are eligible dependent on the level of the long-term disability. (Individuals with a primary diagnosis of a substance abuse disorder or intellectual disabilities are not the intended client group.)

   Does the client have a secondary co-occurring disorder that also impacts their ability to function in the community?

   Substance abuse disorder: ☐ Yes ☐ No
   Describe:

   Other co-occurring disorder: ☐ Yes ☐ No
   Describe:

3. Does the client exhibit significant functional impairment as demonstrated by at least one of the following conditions?

   ☐ Significant difficulty consistently performing the range of practical daily living tasks required for basic adult functioning in the community (e.g. caring for personal business affairs; obtaining medical, legal or housing services; recognizing and avoiding common dangers or hazards to self and possessions; meeting nutritional needs, maintaining personal hygiene)

   Describe:

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☐ Significant difficulty maintaining consistent employment at a self-sustaining level or significant difficulty consistently carrying out the homemaker role (e.g., household meal preparation, washing clothes, budgeting, or child-care tasks and responsibilities).

Describe:

☐ Significant difficulty maintaining a safe living situation (repeated evictions, or loss of housing)?

Describe:

4. Clients with one or more of the following indicators of continuous high service needs:
☐ High use of acute psychiatric hospitals (two or more admissions per year) or psychiatric emergency services.
☐ Intractable (i.e., persistent or very recurrent) severe major mental health symptoms (affective psychotic, suicidal).
☐ Coexisting substance abuse disorder of significant duration (greater than six months).
☐ High risk or recent history of criminal justice involvement (e.g. arrest, incarceration).
☐ Significant difficulty meeting basic survival needs, residing in substandard housing, homelessness, or imminent risk becoming homeless.
☐ Residing in an inpatient or supervised community residence, but clinically assessed to be able to live in a more independent living situation if intensive services are provided, or requiring a residential or institutional placement if more intensive services are not available.
☐ Difficulty effectively utilizing traditional office-based outpatient services.

EVALUATOR:
Agency:
Name:
Title:
Phone Number:

Signature: _____ Date: _____

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ACT Services Determination:

Patient accepts ACT Services: ☐
Patient refuses ACT Service: ☐
ACT Program accepts and agrees that the referred patient meets program eligibility criteria: ☐
ACT Program denies referral: ☐
Specific reason(s) for denial:

If denied, please identify alternative community-based services to be provided:

_____ _____
Signature CCO Organization

_____ _____
Signature ACT Services Representative

Date:_____

Phone: _____
Email: _____

Submit form via secured email to:

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