

Client Name		DOB	
Referral Received		ACT Provider	
Assessment Date			

Medical Necessity Criteria:

	Criteria Met	Criteria Not Met
Adult, 18 years of age or older	<input type="checkbox"/>	<input type="checkbox"/>
Primary diagnosis of schizophrenia or other psychotic disorder (schizoaffective or bipolar disorder)	<input type="checkbox"/>	<input type="checkbox"/>
<i>Must meet at least two of the following criteria:</i>		
At least two psychiatric hospitalizations in the past 12 months or lengths of stay totaling over 30 days in the past 12 months including psychiatric emergency services	<input type="checkbox"/>	<input type="checkbox"/>
Intractable (persistent or very recurrent) severe major symptoms	<input type="checkbox"/>	<input type="checkbox"/>
Co-occurring mental illness and substance use disorders with more than six months duration at the time of contact	<input type="checkbox"/>	<input type="checkbox"/>
High risk or recent history of criminal justice involvement	<input type="checkbox"/>	<input type="checkbox"/>
Literally homeless, imminent risk of being homeless, or residing in unsafe housing	<input type="checkbox"/>	<input type="checkbox"/>
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	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty effectively utilizing traditional case management or office-based outpatient services, or evidence that they require a more assertive and frequent non-office-based service to meet their clinical needs	<input type="checkbox"/>	<input type="checkbox"/>

If client refuses services, please have member sign. If member refuses, please also indicate below.

Client Signature: _____ Date: _____

Please give rationale for why member **does not meet** medical necessity for ACT level of care:

Is there evidence/history of TBI or ID? Yes No

As part of the assessment, have any structural tools been performed to provide evidence of cognitive impairment; TBI or ID, if yes please indicate structure tools and findings:

Based on your assessment, indicate your recommendations: