Program Description

Assertive Community Treatment (ACT) is an evidence-based practice that provides community-based, multidisciplinary mental health treatment for individuals with severe and persistent mental illness. The goal of ACT is to lessen or eliminate the debilitating effects that the symptoms of mental illness can have on functioning and quality of life by providing the majority of treatment, rehabilitation, and support services that individuals need to achieve their goals and live independently in their community.

ACT services are tailored for each person and address their preferences and identified goals established through relationship building and individualized assessments. The teams work collaboratively to provide services in community locations that can be available 24 hours a day and 365 days a year. The services that the teams are required to provide include:

- Service coordination
- 24-hour crisis assessment and intervention
- Symptom assessment and management
- Medication prescription, administration, monitoring, and documentation
- Co-occurring substance use services
- Employment services
- Activities of daily living
- Social/interpersonal relationship and leisure-time skill training
- Peer support services
- Support services
- Education, support, and consultation to families

Admission Criteria

Patients **must meet all seven** of the admission criteria:

1. A primary diagnosis of schizophrenia or other psychotic disorders, such as schizoaffective disorder or bipolar disorder, as defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM V or any subsequent revisions thereafter). Individuals with a primary diagnosis of substance use disorder, intellectual disability, or brain injury are not the intended consumer group.
2. Must be 18 years of age or older.
3. At least two or more acute episodes of psychiatric inpatient treatment within the past 12 months or 30 days or more on an acute psychiatric unit or State Hospital during the last 12 months, or three or more contacts with crisis intervention/emergency services within the past six months.
4. Significant difficulty meeting basic survival needs, residing in substandard housing, homelessness, or imminent risk of becoming homeless.
5. The individual does not have a primary diagnosis of a Personality Disorder, Traumatic Brain Injury, or Intellectual Disability.
6. Difficulty effectively utilizing traditional community-based services: outpatient, case management, etc.
7. History of inadequate follow through with elements of a treatment/service plan that resulted in member psychiatric or medically instability. OR
8. The individual does not meet all of the admission criteria described above, but is designated as appropriate to receive ACT services by a multidisciplinary team, which includes participation by representatives of CBH Clinical Management in consultation with an ACT provider, CBH physician advisor, or the county Office of Behavioral Health.

For more information about ACT services, please contact Elisabeth Caba, BHCMU Supervisor, at ***Elisabeth.Caba@Phila.gov****.*

Assertive Community Treatment (ACT) Cover Sheet

Mailed or faxed referrals will NOT be reviewed.

From:

Referring Agency/Program			
Referring Staff's Name			
Contact Phone		Contact Fax	
Contact Email			
Other Case Manager(s)		Contact Information	

ACT referral is being requested for:

Applicant Last Name		First Name	
Applicant DOB		SS#	

Consent to Release Information

I authorize the disclosure of the ACT Application and all related supporting documents, including confidential medical and mental health information, to Community Treatment Teams Philadelphia or PATH for the purposes of assessment for ACT services. I understand that I may revoke this authorization at any time. My revocation must be in writing. I am aware that my revocation will not be effective if the persons I have authorized to use and/or disclose my protected health information have already taken action because of my earlier authorization. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment nor will it affect my eligibility for benefits.

Applicant Signature: _____ Date: _____

Print Name and Title: _____

Witness Signature: _____ Date: _____

Print Name and Title: _____

ACT Application Packet Instructions

The ACT Application Packet consists of two forms as well as supporting documentation. A completed application must include the following (check all boxes to indicate paperwork is attached):

- ☐ ACT Cover Sheet with signed consent to release information
- ☐ ACT Referral Form completed within the last 30 days (Please answer all questions; type answers when possible or write legibly.)
- ☐ Psychiatric Evaluation or ADAPT Assessment completed within the last year for cases directly referred from Extended Acute Care service (EAC)
- ☐ Comprehensive Psychiatric Evaluation signed by a psychiatrist or a psychiatric nurse practitioner and completed within the last 90 days for acute inpatient or EAC referrals

ACT Referral Summary

Medical Necessity Criteria (MNC) must be met for eligibility for ACT Services. Answer questions below and use additional pages if necessary.

1. Provide a brief statement regarding applicant's current level of functioning including mental status, relationship with family, community supports, etc.

2. Does the applicant have a primary diagnosis of schizophrenia or other psychotic disorder (schizoaffective or bipolar disorder)? ☐ **Yes** ☐ **No** ☐ **Unknown**

   If "Yes," please describe the symptoms and history that led to this applicant receiving a primary diagnosis of schizophrenia, schizoaffective disorder, or bipolar disorder.

3. Does the applicant have (a) at least two or more acute episodes of psychiatric inpatient treatment within the past 12 months, (b) 30 days or more on an acute psychiatric unit or State Hospital during the last 12 months, or (c) three or more contacts with crisis intervention/emergency services within the past six months?

   ☐ **Yes** ☐ **No** ☐ **Unknown**

   If "Yes," please describe the psychiatric hospitalizations over the past 12 months, including the precipitating factors that led to admission (e.g., harm to self, harm to others, inability to care, voluntary commitment) and responsiveness to treatment. Please describe the applicant's utilization of crisis intervention/emergency services over the past six months, including patterns of behavior that led to contacts.

4. Does the applicant have significant difficulty meeting survival needs, residing in substandard housing, homelessness, or imminent risk of becoming homeless? ☐ **Yes** ☐ **No** ☐ **Unknown**

If "Yes," please describe.

5. Does the applicant have a previous or current diagnosis of a personality disorder, traumatic brain injury, or intellectual disability? ☐ **Yes** ☐ **No** ☐ **Unknown**

Is this considered a primary diagnosis? ☐ **Yes** ☐ **No**

What factors (e.g., behaviors, functional deficits, etc.) led to this diagnosis?

6. Has the applicant had difficulty effectively utilizing community-based services (e.g., PCP appointments, outpatient therapy, medication management, medication adherence/non-adherence and consequences, case management, SUD services, etc.)? ☐ **Yes** ☐ **No** ☐ **Unknown**

If "Yes," please describe these difficulties (e.g., engaged, rarely attended, never attended, or refused services).

7. What community-based supports and interventions/strategies (e.g., outpatient, inpatient rehab, IOP, etc.) have been attempted within the last 12 months to engage or link the applicant to Community Behavioral Health services?

8. Has the applicant had a history of inadequate follow-through with elements of a treatment/service plan that resulted in member psychiatric or medical instability? ☐ **Yes** ☐ **No** ☐ **Unknown**

If "Yes," please describe the applicant's typical obstacles to following through with treatment/service planning.

9. Please describe the applicant's health/medical status, including conditions, adherence with medication and medical treatments, and impact on their overall day-to-day function, that may put them at risk in the community.

Authorized Signature: _____ **Date:** _____

Print Name and Title: _____

Email Address: _____ **Phone Number:** _____

ACT Referral Form

Date of Referral		**Person Completing Form**	

Section A: Demographics

First Name		**Last Name**	
DOB		**Social Security #**	
Address Line 1		**Address Line 2**	
City/ST/ZIP		**Phone**	

*Please note: Determination **cannot** be made without an address to locate the participant. If the applicant is homeless, please note the shelter/drop-in center or location where they may be contacted.*

Emergency Contact		**EC Phone**	
Relationship to EC			
CIS #		**BSU #**	**Medicaid #**

Gender	☐ Male ☐ Female ☐ Transgender ☐ Other
Race *(Check all that apply.)*	☐ Black/African American ☐ Asian ☐ White ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaskan Native ☐ Other/Unknown:
Ethnicity *(Check all that apply.)*	☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Unknown
Primary Language	☐ English ☐ Spanish ☐ Mandarin ☐ Cantonese ☐ Vietnamese ☐ Hindi ☐ Cambodian (Khmer) ☐ ASL ☐ No Language ☐ Other:
English Proficiency	☐ Does Not Speak ☐ Poor ☐ Fair ☐ Good ☐ Excellent

If applicant is hospitalized and being discharged to a different address or if the applicant is homeless and moving into housing, please indicate the address/contact information to which they will be transferred below:

Organization/Facility Name			
Address Line 1		**Address Line 2**	
City/ST/ZIP		**Phone**	

Section B: Characteristics

1. Where does the applicant live **currently**? (Check one.)

- ☐ State Hospital (NSH/other)
- ☐ Hospital – Psychiatric
- ☐ Hospital – Medical
- ☐ Hospital – Detox/Rehab
- ☐ Correctional Facility – Prison
- ☐ Correctional Facility – Jail
- ☐ LTSR
- ☐ MH Residence (other than LTSR)
- ☐ Nursing Home
- ☐ IDS/CLA
- ☐ Recovery House
- ☐ PCBH
- ☐ Family Home
- ☐ Independent Living
- ☐ Homeless/Shelter
- ☐ Unknown
- ☐ Other:

If applicable:

Facility Name			
Address Line 1		Address Line 2	
City/ST/ZIP		Occupancy (Months)	

2. Current Employment Status (Check one.)

☐ Competitive Employment ☐ Unknown ☐ No Employment ☐ Other:

3. Income or benefits being received currently (Check all that apply.)

- ☐ Wages/Salary/Self-Employed
- ☐ SSI
- ☐ SSDI
- ☐ Social Security/Retirement/Survivor Benefits
- ☐ Veterans Benefits
- ☐ Workers' Compensation
- ☐ Medicare
- ☐ Medicaid
- ☐ Cash Assistance/Food Stamps
- ☐ Private Insurance
- ☐ Ineligible
- ☐ None
- ☐ Other:

4. Do you have a representative payee? ☐ Yes ☐ No

If "Yes," complete the following.

Payee Name			
Payee Phone		Payee Email	

Section C: Criminal Justice Involvement

1. Criminal Justice Status (Check all that apply.)

- ☐ **No Criminal History**
- ☐ **No History of Probation/Parole**
- ☐ **Under Supervision of MH Court**
- ☐ **Under Supervision of Probation/Parole**
- ☐ **State Incarceration**
- ☐ **County Detention**
- ☐ **NSH - Building 51**
- ☐ **Megan's Law Registrant**

2. Does the applicant have any prior felony convictions? ☐ **Yes** ☐ **No**

If "Yes," list the prior convictions and total years incarcerated.

Year	Conviction (e.g., Aggravated Assault)
Total Years Incarcerated	