ACT & TACT REFERRAL FORM

Date of Referral: _____

Name: Date of Birth: Social Security Number: Gender & Pronoun: Primary Language:	Referred to: ☐ Duluth ACT or TACT Team ☐ Mesabi ACT Team
Home Address:	
Current location (if different than above):	
Phone Number(s):	
Please note any known barriers or delays to active enrollment.	
MA Number:	
If PMAP, note health plan:	
Other insurance info:	
Referring Party Name/Agency:	
Email:	
Phone:	
ACT requires one of the following as a primary diagnosis. Please check which is applicable to the referred individual:	
☐ Schizophrenia	☐ Major Depression with psychotic features
☐ Schizoaffective Disorder	☐ Other psychotic disorders
☐ Bipolar Disorder	
☐ Other noted diagnoses:	
Reason for referring to ACT (why is this service level needed, how do you hope it will help the person):	
Current providers (Name, agency, phone) and relevant info:	
Psychiatrist:	
Medical Doctor:	
Therapist:	
Financial Worker:	
Rep Payee/Guardian/Conservator:	
Dentist:	
Probation:	
Family/Other:	
Current sources of income: ☐ SSI ☐ SSDI-RSDI ☐ MFIP ☐ Employment ☐ Other:	
Current medication (attach list if possible):	
Civil Commitment Info (skip this section if no current commitment order)	
Commitment type: ☐ MI ☐ MI/CD ☐ CD ☐ MI&D ☐ Other (specify):	
Order expiration date:	
Other orders: ☐ Jarvis ☐ Price-Sheppard ☐ Other (specify):	

Eligibility Screen: In addition to diagnostic criteria, clinical need must be present. Please check all that apply:

☐ Has functional impairments as demonstrated by at least ONE of the following:

- ☐ Significant difficulty consistently performing the range of routine tasks required for basic adult functioning in the community or persistent difficulty performing daily living tasks without significant support or assistance
- ☐ Significant difficulty maintaining employment at a self-sustaining level or significant difficulty consistently carrying out the head-or-household responsibilities
- ☐ Significant difficulty maintaining a safe living situation

☐ Has need for continuous high-intensity services as evidenced by at least TWO of the following:

- ☐ Two or more psychiatric hospitalizations or residential crisis stabilization services in the previous 12 months
- ☐ Frequent utilization of mental health crisis services in the previous six months
- ☐ 30 or more consecutive days of psychiatric hospitalization in the previous 24 months
- ☐ Intractable, persistent, or prolonged severe psychiatric symptoms
- ☐ Coexisting mental health and substance use disorders lasting at least six months
- ☐ Recent history of involvement with the criminal justice system or demonstrated risk of future involvement
- ☐ Significant difficulty meeting basic survival needs
- ☐ Residing in substandard housing, experiencing homelessness, or facing imminent risk of homelessness
- ☐ Significant impairment with social and interpersonal functioning such that basic needs are in jeopardy
- ☐ Coexisting mental health and physical health disorders lasting at least six months
- ☐ Residing in an inpatient or supervised community residence but clinically assessed to be able to live in a more independent living situations if intense services are provided
- ☐ Requiring a residential placement if more intensive services are not available
- ☐ Difficulty using traditional office-based outpatient services effectively

If available, include the following records. If not available, we may need to work with you and the individual to get records before making an eligibility determination:			
☐ Diagnostic Assessment (within one year)			
☐ Current and historical hospitalization records/dates			
☐ Civil commitment/pre-petition paperwork (current/historical)			
☐ Functional Assessment			
☐ LOCUS			
Please either fax or send referrals via secure email to the team you are referring to. We are happy to consult prior to your referral.			
Duluth T-ACT Team	PH: (218) 727-4200	FAX: (218) 727-4559	ACT/TACTReferrals@stlouiscountymn.gov
Duluth ACT Team	PH: (218) 728-7922	FAX: (218) 728-7923	ACT/TACTReferrals@stlouiscountymn.gov
Mesabi ACT Team	PH: (218) 471-7730	FAX: (218) 520-0641	AbrahamsonS@stlouiscountymn.gov

To Be Completed by ACT Team Leader

☐ Client will not be opened with ACT services. Reason:

☐ Client will be opened with ACT Team, service need cannot be met with other available community-based services. There are no indications that other available community-based services would be equally or more effective as evidenced by consistent and extensive efforts to treat the individual; and

☐ In the written opinion of a licensed mental health professional, has the need for mental health services that cannot be met with other available community-based services, or is likely to experience a mental health crisis or require a more restrictive setting if assertive community treatment is not provided.

Mental Health Professional signature:_____ Date: _____