RHD Iowa ACT Referral Info Packet

What is ACT?

Assertive Community Treatment (ACT) is an evidence – based practice that improves outcomes for people with severe and persistent mental illness who are most at-risk of psychiatric crisis, hospitalization, and involvement in the criminal justice system. ACT is one of the oldest and most widely researched evidence-based practices in behavioral healthcare for people with severe and persistent mental illness. As a national social service provider, RHD has over 10 fidelity measured ACT Teams across the county, with three being in the state of Iowa. The RHD Iowa ACT system is comprised of teams located in Cedar Rapids, Knoxville and Waterloo areas of Iowa. Each team supports individuals in an approximate catchment area within a 50-mile radius of the program location.

What does ACT consist of?

Assertive Community Treatment (ACT) Team is an interdisciplinary team that ensures a recovery- oriented system of care, with a full range of treatment services, 24 hours a day, 7 days a week via telephone on call access. The Team consists of Psychiatrist/ARNP, Master's and Bachelor's – level Professionals, Registered Nurse(s), Substance Abuse Specialist, Vocational specialist, Peer Support Specialist, and a Program Assistant. Team member's work together with consumers to; promote symptom stability, appropriate use of medication, encourage personal growth, enhance community living skills and promote and maintain the highest possible level of functioning in the community.

What do I do to get ACT services or to help someone else to get ACT services?

In order for someone to receive ACT services, they must first meet the qualifications of the services as listed on page 2 of this document and receive Medicaid funding. If you believe that, the individual you are referring may be eligible, but does not have Medicaid funding, please reach out to your local DHS office to complete a Medicaid application prior to referral submission.

Thank you for considering Resources for Human Development
to provide behavioral health services
to those in need.

Please review the information below and select all applicable responses

ACT Admission Criteria:

A. The individual must have one of the following diagnoses: (Check all that apply)

- ☐ Schizophrenia
- ☐ Bipolar disorder
- ☐ Major depressive disorder
- ☐ Other psychotic disorder

B. The individual may also have a co-occurring disorder: (Check all that apply)

☐ Substance use disorder ☐ Developmental disability

C. Include one or more of the following service needs: (Check all that apply)

- ☐ 2 or more acute psychiatric hospitalization and/or 4 or more psychiatric emergency room visits in the last 6 months
- ☐ Persistent and severe symptoms of a psychiatric disability that interferes with the ability to function in daily life
- ☐ 2 or more interactions with law enforcement in the past year for emergency services due to mental illness or substance use
- ☐ Currently residing in an inpatient bed, but clinically assessed to be able to live in a more independent setting, if intensive services were provided
- ☐ 1 or more incarcerations in the past year related to mental illness and/or substance use

D. Must have one of the following: (Check all that apply)

- ☐ Inability to participate or remain engaged or respond to traditional community-based services
- ☐ Inability to meet basic survival needs, or residing in substandard housing, homeless or at imminent risk of becoming homeless

E. Must have three of the following: (Check all that apply)

- ☐ Evidence of co-existing mental illness and substance use/dependence
- ☐ Significant suicidal ideation, with a plan and ability to carry out within the last 2 years
- ☐ Suicide attempt in the last 2 years
- ☐ History of violence due to untreated mental illness/substance use within the last 2 years
- ☐ Lack of support systems
- ☐ History of inadequate follow-through with treatment plan, resulting in psychiatric or medical instability
- ☐ Threats of harm to others in the past 2 years
- ☐ History of significant psychotic symptomatology, such as command hallucinations to harm other.

Date: _____
Referring Organization: _____
Referral Contact: _____
Telephone: _____
Email: _____

Team referring to:

☐ ACT Cedar Rapids (ECR)
☐ ACT Knoxville (CROSS)
☐ ACT Waterloo (CSS)

Consumer Information

Name:
First: _____Middle _____Last: _____
DOB: _____ Gender: _____
Telephone: _____ Social Security #: _____
Current Address: _____
City: _____ State: _____ Zip code: _____

Current Residence Type: ☐ Has secure housing ☐ Lacks secure housing
☐ Homeless/Shelter ☐ Residential care facility (RCF) ☐ Mental Health Institution (MHI)
☐ Crisis Stabilization Center ☐ Currently Incarcerated
Name of Facility (if applicable): _____

Primary Effective:
Insurance: _____ Policy #: _____ Date: _____

Secondary Effective:
Insurance: _____ Policy #: _____ Date: _____

Current Monthly Income: _____
Income Source: ☐ Employment ☐ SSI ☐ SSDI ☐ NONE

Has a legal guardian: ☐ YES ☐ NO
Legal Guardian Contact: _____ Telephone: _____
Emergency Contact: _____ Telephone: _____

Receives IHH/Case Management services: ☐ YES ☐ NO
Contact: _____ Organization: _____
Telephone: _____ E-mail: _____

Has a current Mental Health Provider: ☐ YES ☐ NO
Contact: _____ Organization: _____
Telephone: _____ E-mail: _____

When submitting a referral please include the following documents (if available):
Including these documents will help to expedite the intake process and aid in providing continuity of care to the individual served.

☐ Psychiatric Evaluation
☐ Psychosocial Assessment
☐ Signed Release of Information (provided in this document)
☐ Medication Records & Lab Results

Please list any additional comments or information

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To learn more about our organization, please visit: rhd.org/iowa

Submit referral and supporting documents to

IAACTREFERRAL@RHD.ORG

* Please place the name of the team you are referring to in the subject line of the email*

RHD IOWA- Assertive Community Treatment (ACT) Teams
Consent for Request/Release of Information

I hereby authorize the RHD Iowa ACT to request/release the following information from the health records of:

Name: _____ **DOB:** ____/_____/_____

I consent to have the information of the above listed individual

☐ Obtained From
OR
☐ Released To

Individual/Organization: _____

Address: _____

Telephone: _____ Fax (if applicable): _____

Specific Medical/Mental Health Information to be *obtained or released (as indicated above)*:

☐ Discharge Summary	☐ History & Physical	☐ Face Sheet	☐ Presence in Treatment
☐ History of Relapse	☐ Frequency of Relapse	☐ Diagnosis	☐ Aftercare Treatment Plan
☐ Progress in Treatment	☐ Nature of Project	☐ Referral Source	☐ Mental Health Records
☐ Drug & Alcohol Records	☐ Consultations	☐ Referral for Services	☐ Prognosis: _____
☐ Lab Reports	☐ Financial Info	☐ Medication	☐ Other: _____

For the Specific Purpose of:

☐ Keep Family/SO Informed	☐ Assist with Legal Issues	☐ Update Medical Records	☐ Discharge Aftercare Planning
☐ Emergency Contact	☐ Settle Insurance Claim	☐ Application for Insurance	☐ Continuity of Care
☐ Billing for Pharmacy	☐ Medication/Pharmacy Care	☐ Fill Out Disability Forms	☐ Other: _____
☐ Collateral Contact	☐ Insurance/ Billing	☐ Financial Assistance	

This authorization expires on: ____/_____/_____
(No later than one year from the date of consent)

I understand this release will include health information relating to (check all that apply):

Drug and Alcohol Abuse	☐ YES	☐ NO	_____ (Initial Here)
Mental Illness	☐ YES	☐ NO	_____ (Initial Here)
HIV or AIDS	☐ YES	☐ NO	_____ (Initial Here)

I understand that if the organization authorized to receive the information is not a health care provider or health plan covered by federal privacy regulation, the information described above may be re-disclosed and no longer protected by privacy regulations. I understand that I may revoke this consent in writing at any time except to the extent that RHD has already used or released in reliance of this authorization.
I understand this consent waives my right to confidentiality and privacy under federal regulations, including Code of Federal Regulations Title 42, Part 2 (CFR42), State requirements (Iowa code chapter 228) and the Health Insurance Portability Accountability Act (HIPAA) that protect my Personal Health Information. However, I understand that this authorization is only for the specific purpose between the entities and specific purposes noted above. Further re-disclosure without additional authorization or as otherwise permitted by law is prohibited under CFR 42 and HIPAA.

Name: _____ _____ Date: _____
Client or Legal Representative Signature

Name: _____ _____ Date: _____
Witness Signature