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

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

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*

Authorization for Release of Protected Health Information

Participant Name: _____Date of Birth: _____

RHD Program Name and Address: _____

_____

I, _____
( ) Participant ( ) Parent ( ) Legal Guardian **(please check one)**

authorize the above named program of Resources for Human Development, Inc. (RHD) to
( ) receive from and/or ( ) release to the below named person or entity:

_____
_____
_____
_____

The Following Specific Protected Health Information (please check all that apply)

( ) Biopsychosocial Evaluation ( ) Treatment, Service, or Recovery Plans ( ) Progress Notes
( ) Psychiatric Evaluation ( ) Psychiatric Progress Notes ( ) Medications
( ) Drug/Alcohol Evaluation ( ) Drug/Alcohol Treatment Notes ( ) Attendance
( ) Physical Health Records ( ) Nursing Notes ( ) Lab Reports
( ) Diagnosis ( ) Discharge Summary ( ) Consultations
( ) Response to and Progress in Treatment and/or Services
( ) Other: _____

Specify dates (or date range) if applicable: _____

For the Specific Purpose of: (please check all that apply)

( ) Care Coordination with healthcare providers ( ) Care Coordination with Natural Supports
( ) Update Medical and Treatment Records ( ) Apply for Financial/Insurance Benefits
( ) Continuity of Care ( ) Discharge Planning
( ) Assist with Legal Issues ( ) Assist with Housing Issues
( ) Other: _____

I understand the following:

1. Authorizing the release of this information is voluntary, and I can refuse to sign this authorization form.
2. Neither RHD nor any RHD program will refuse to offer Participant services if this authorization form is not signed.
3. This authorization form may be withdrawn at any time by notifying RHD in writing at the Program address above. However, any revocation will not affect releases or other actions taken prior to such revocation.
4. If the entity or person authorized to receive the above information is not a health plan or health care provider, the information in the records may no longer be protected under any applicable privacy law or regulation and may be released.
5. A copy of this signed form has been made available to me.

This authorization will expire in one year unless otherwise specified as follows: _____
_____
The expiration date may not be more than one year after the date of this authorization.

Expiration Date: _____

Signature of ( ) Participant ( ) Parent ( ) Legal Guardian **(Please Check One)**

_____ Date: _____

Printed Name:

_____

RHD Staff Signature: **(required for release of drug/alcohol or mental health information)**

_____ Date: _____

RHD Staff Printed Name:

_____

Revised January 1, 2017