Upper Mississippi Mental Health Center
Headwaters ACT
Referral Information Form

Date of Referral: _____ County of Financial Responsibility: _____

Recipient Name: _____ County of Residence: _____

Phone: _____ Date of Birth: _____

Primary Address: _____

Social Security #: _____

Primary Insurance: _____ Insurance #: _____

Secondary Insurance: _____ Insurance #: _____

Referral Source: _____ Referent's Phone Number: _____

Referent's Email: _____ Cadi Waiver Services? Yes No

Reason for Referral: _____

_____

Is the client aware and in support of this referral? ☐ **Yes** ☐ **No**

Diagnosis

Most recent diagnostic assessment date: _____ Completed by: _____

DSM 5: _____

DSM 5: _____

DSM 5: _____

DSM 5: _____

Past and Present Service Providers/Involved Persons

Please provide who the client has worked with in the past 5 years

County Social Worker: _____ Agency: _____ Phone: _____

Is county social worker aware of this referral? ☐ Yes ☐ No In support of referral? ☐ Yes ☐ No

Psychiatrist: _____ Clinic: _____ Phone: _____

Is psychiatrist aware of this referral? ☐ Yes ☐ No In support of referral? ☐ Yes ☐ No

Therapist: _____ Clinic: _____ Phone: _____

Is therapist aware of this referral? ☐ Yes ☐ No In support of referral? ☐ Yes ☐ No

Financial Worker: _____ Agency: _____ Phone: _____

Protective Payee: _____ Agency: _____ Phone: _____

ARMHS Worker: _____ Agency: _____ Phone: _____

Primary Doctor: _____ Agency: _____ Phone: _____

Guardian/Conservator: _____ Phone: _____

Continued on next page

Probation/DOC: _____ Phone: _____

Other: _____ Phone: _____

Other: _____ Phone: _____

Other: _____ Phone: _____

Medical Information

Current Medications: _____

_____

_____

_____

Pharmacy: _____

Current living situation: _____

Support services not funded: _____

_____

Current sources of income: _____

Is the Recipient under a civil commitment? ☐ Yes ☐ No Type: _____ Expiration Date: _____

Is the recipient interested in Native American traditional healing or ceremony? ☐ Yes ☐ No

Supporting Documentation

The following documentation should be included if available with this referral form. Please check all that is included:

- ☐ Release of Information for all information included
- ☐ Documentation of serious mental illness
- ☐ Current assessments
  - ☐ Functional assessment
  - ☐ Diagnostic assessment
  - ☐ Other pertinent clinical assessments
- ☐ ICSP Plan (most recent)
- ☐ Other pertinent treatment information (support services)
  - ☐ Mental health treatment
  - ☐ Medical
  - ☐ Employment
  - ☐ Housing
  - ☐ Education
  - ☐ Financial/Benefits
- ☐ Crisis Plan
- ☐ Legal: pertinent to civil commitment/ criminal history (current or past)
- ☐ Guardian/Conservatorship documentation

Referral Process

This referral form and any supporting documentation should be faxed to (218)-444-5491, or delivered to 408 Beltrami Ave NW, Suite #102, Bemidji, MN 56601

It is the intent of our programs to gather as much current and past clinical information prior to admission in order to ensure that potential clients and current treatment providers are fully informed of services provided within our programs but also to safeguard against inappropriate admissions.

Once referral information is received, we will be in contact with you to further discuss our program and this recipient's eligibility to the program. If you have other questions regarding our programs, please to not hesitate to contact the main office at (218) 444-4429.

Additional eligibility criteria for each program is included on the following page. Thank you for your referral.

Eligibility Criteria

An eligible <u>ACT</u> service recipient is an individual who:

- ☐ Is 18 years of age or older and enrolled in MN Medical Assistance.
- ☐ Has a primary diagnosis of a severe and chronic mental disorder as listed in the diagnostic nomenclature (DSM-V) that seriously impairs their functioning in the community.
  - ☐ Priority is given to people with schizophrenic disorders, other psychotic disorders, schizoaffective disorder, bipolar disorder, and major depressive disorder with psychotic features.
- ☐ Experiences significant functional impairments as demonstrated by at least one of the following conditions:
  - ☐ Inability to consistently perform activities daily living.
  - ☐ Inability to be consistently employed at a self-sustaining level or inability to consistently carry-out homemaker roles
  - ☐ Inability to maintain a safe living situation.
- ☐ Has one or more of the following:
  - ☐ High utilization of acute psychiatric hospitalizations (e.g., 2 or more admissions per year) and/or psychiatric emergency services (e.g., 6 or more per year);
  - ☐ Dual diagnosis/co-existing substance use disorder of six months or more in duration;
  - ☐ Significant independent living instability;
  - ☐ Homelessness;
  - ☐ Very frequent use of mental health and related services that result in poor outcomes;
  - ☐ Repeated criminal justice/legal involvement despite mental health intervention.
  - ☐ Has had a lack of engagement in traditional mental health treatment strategies, or traditional mental health services have been inadequate to meet the client's needs.
- ☐ Reside in or around the Bemidji area. (See Service Area Policy)