Lower Shore Clinic, Inc.

505 E. Main Street, Salisbury, MD 21804

ACT

106 Williams Port Cir, Salisbury MD
Servicing: Somerset, Worcester, Wicomico, Dorchester, Talbot, Caroline
Phone: 410-341-9696
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Checklist for Individuals who meet basic criteria for ACT

Mobile Treatment is designed for adults with serious mental disorders which are exemplified by non-compliance and vulnerability to provide treatment in the least intensive setting that is able to meet the Individual`s clinical needs. These services are provided by a multidisciplinary treatment team and are available to the consumer on a 24/7 basis.

(*Not intended for those whose only barrier is transportation)*

Admission Criteria: All of the following criteria are necessary for admission:

1. The consumer has a PMHS specialty mental health DSM diagnosis included in the Priority Population, which is the cause of significant psychological, personal care, and social impairment.

☐	295.90/F20.9	Schizophrenia	☐	296.44/F31.2	BP I Disorder, MRE Manic, w/ Psychotic
☐	295.40/F20.81	Schizophreniform Disorder	☐	296.53/F31.4	BP I Disorder, MRE Depressed, Severe
☐	295.70/F25.0	Schizoaffective Disorder, BP Type	☐	296.54/F31.5	BP I Disorder, MRE Depressed, w/ Psychotic
☐	295.70/F25.1	Schizoaffective Disorder, Depressive Type	☐	296.40/F31.0	BP I Disorder, MRE Hypomanic
☐	298.8/F28	Other Specified Schizophrenia Spectrum	☐	296.40/F31.9	BP I Disorder, MRE Hypomanic, Unspecified
☐	298.9/F29	Unspecified Schizophrenia Spectrum	☐	296.7/F31.9	BP I Disorder, MRE Unspecified
☐	297.1/F22	Delusional Disorder	☐	296.80/F31.9	Unspecified BP and Related Disorder
☐	296.33/F33.2	MDD, MRE, Severe	☐	296.89/F31.81	BP II Disorder
☐	296.34/F33.3	MDD, MRE, w/ Psychotic Features	☐	301.22/F21	Schizotypal Personality Disorder
☐	296.43/F31.13	BP I Disorder, MRE Manic, Severe	☐	301.83/F60.3	Borderline Personality Disorder

2. The impairments result in at least one of the following:

- ☐ A clear, current threat to the Individual's ability to live in his/her customary setting, or the Individual is homeless, and would meet the criteria for a higher level of care if mobile treatment services were not provided. The individual is homeless.
- ☐ An emerging/impending risk to self or others.
- ☐ Inability to engage in traditional outpatient treatment.

3. Inability to form a therapeutic relationship on an ongoing basis as evidenced by at least one of the following:

- ☐ Frequent use of emergency rooms for psychiatric reasons.
- ☐ Psychiatric hospitalizations
- ☐ Arrest for reasons associated with the Individual's mental illness.

Referral Process

1. **Within 10 working days of receiving a complete referral, the Mobile Treatment Team will arrange for staff to visit applicant in order to conduct a face to face screening assessment to determine needs, strengths, available resources, and willingness to participate in the Mobile Treatment Services offered.**

2. **Within 5 working days of the screening assessment, the individual and the referral source will be notified whether the Mobile Treatment Team:**
   - **a. Accepts the individual and will begin enrollment process**
   - **b. Will accept the individual, following an updated review of the individual's eligibility, when when program capacity permits.**
   - **c. Denies services due to ineligibility.**
   - **d. Will accept the individual, following an updated review of the individual's eligibility, after the individual's discharge or release from an inpatient facility or detention center.**

RELEASE/AUTHORIZATION

I, _____, authorize the release/exchange of all available information between the following agencies/individuals to support my application to Lower Shore Clinic, Inc. If services are terminated or denied, I authorize the release of information pertaining to the denial or termination, including the reason for these actions, effective date, and, when appropriate, discharge plans.

This Release/Authorization Form is effective for 90 days.

Emergency Contact: _____Relationship:_____

Address: _____Phone Number:_____

Treatment Provider: _____Phone Number:_____

Somatic Physician: _____Phone Number:_____

Referring Agency: _____Phone Number:_____

Address:_____ Phone Number:_____

I understand that application for Mobile Treatment Services is being made on my behalf and agree to this referral for services.

Signed: _____ Date: _____

Witness:_____ Date:_____

REFERRAL FORM

Please Print

***Client's Name*: _____ *Date*: _____**

***Gender*: □ Male □ Female *Currently inpatient?* □ Yes □ No**

***Current living arrangement*: (If hospitalized, living arrangement prior to hospitalization?**
□ Live alone □ Live with family/friend □ Homeless □ RRP □ Other _____

***Address*: _____**

***Home Phone:* _____ *Day Time Phone*: _____**

***SS#*_____ *Birth Date*: _____ *Age*: _____**

***Marital Status*:**

□ Single □ Married □ Divorced □ Separated □ Widowed # Children_____

***Ethnic Group*:**

□ African American □ Hispanic □ White Non-Hispanic

□ Asian/Pacific Island □ American Indian/Alaskan Native □ Other_____

1. Current DSM-V Diagnosis: (Pleast list # and name)

Behavioral Diagnoses: _____

Primary Medical Diagnoses:_____

Social Elements Impacting Diagnosis: (Circle all that apply)

Financial Social Environment Occupational Primary Support Group

Housing Homelessness Access to healthcare Legal

Other:_____

Current GAF:_____ Date:_____ Prior GAF:_____ Date:_____

2. Currently Medication Compliant? □ Yes □ No

Please list Medications currently prescribed, if known, as well as who prescribed. You may attach a separate sheet. _____

_____

_____

3. Presenting Problems: (Check all that apply)

□ **Visual or Hearing Impairment: Explain**_____

□ **Physical Handicap: Explain** _____

□ **Chronic Health Problems/Medical/Somatic Including Special Dietary Needs: Explain**_____

_____

□ **Drug or Alcohol Abuse: Explain**_____

□ **Social/Interpersonal Conflicts Including Marital & Family Problems:**

Explain_____

_____

□ **Depression/Mood Disorder: Explain**_____

_____

□ **Suicide Threat/Attempt (Date of Most Recent Occurrence): Explain**_____

_____

□ **Homicidal Threat/Attempt (Date of Most Recent Occurrence): Explain** _____

_____

□ **Thought Disorder: Explain**_____

_____

□ **Assault/Rape/Abused Victim: Explain**_____

_____

□ **Other: Explain**_____

4. Level of Functioning: Does he/she read? □ Yes □ No Does he/she write? □ Yes □ No

Highest Grade Completed, if known: _____ Special Education? □ Yes □ No

5. Psychiatric Hospitalization History (List 3 most recent): Total No. of Hospitalizations_____

Dates_____ Institution_____

Dates_____ Institution_____

Dates_____ Institution_____

6. Forensic Status:

□ **No forensic status/unknown** □ **On parole or probation**

□ **Conditional Release** □ **Not criminally responsible**

Explain Conditions of Release, Parole, Probation, or pending legal matters (i.e. upcoming court dates):_____

Does the individual have access to weapons? □ Yes □ No □ Unknown

If yes, please list: _____

Describe any history of criminal behavior:_____

7. Has the individual been referred to or participated in any of the following? If yes, to any which and when?

□ Yes □ No **Addictions Treatment:**_____

□ Yes □ No **Dual-Diagnosis Treatment:**_____

□ Yes □ No **Out-Patient Mental Health Clinic:**_____

□ Yes □ No **Psychiatric Rehabilitation Program, including Residential Rehabilitation/Supervised Housing:**_____

□ Yes □ No **Supported Employment:**_____

□ Yes □ No **Targeted Case Management:**_____

8. Current Entitlement & Financial Information (Complete all that apply or if pending please note):

□	**Social Security**	**Amount**_____	□	**PAA**	**Amount**_____
□	**SSI**	**Amount**_____	□	**VA Benefits**	**Amount**_____
□	**SSDI**	**Amount**_____	□	**Salary/Wages**	**Amount**_____
□	**Other Income**	**Type**_____			**Amount**_____
□	**Medicaid**	**Effective Date:**_____		**Expiration Date:**_____	
□	**Medicare**	**Effective Date:**_____		**Expiration Date:**_____	

Social History

EMPLOYMENT HISTORY: Include all past jobs and reasons for leaving them; also include volunteer positions.

_____

_____

FAMILY HISTORY: Include information about support system, family history of mental illness, siblings, family structure, person(s) with whom individual lives, significant others.

_____

_____

_____

COMMUNITY: Include agency contacts, court involvement, church, and other social groups.

_____

_____

Reason for Referral:

_____

_____

_____

_____

_____

_____