Sanford Health Behavioral Health Center

Headwaters ACT
116 3rd Street NW
Bemidji, MN 56601
(218) 333-2220 (office)
(218) 444-5491 (fax)

SANFORD HEALTH
Behavioral Health

Headwaters Assertive Therapy (ACT) Referral Form

Date: Click or tap here to enter text. County of Financial Responsibility: Click or tap here to enter text.

Recipient Name: Click or tap here to enter text. County of Residence: Click or tap here to enter text.

Phone: Click or tap here to enter text. Date of Birth: Click or tap here to enter text.

Primary Address: Click or tap here to enter text.

Primary Insurance: Click or tap here to enter text._

Secondary Insurance: Click or tap here to enter text.

Referral Source: Click or tap here to enter text. Referent's contact: Click or tap here to enter text.

Referents Email: Click or tap here to enter text. Cadi Waiver? ☐Yes ☐ No

Reason for Referral (details are helpful): Click or tap here to enter text.

Is the client aware and in support of this referral? ☐ Yes ☐ No Click or tap here to enter text.
Is client in support of this referral? ☐ Yes ☐ No Click or tap here to enter text.

Past and Present Service Providers/Involved Persons

(Please provide whom the client has worked with in the past 7 years and contact info. Family support in "other")

Psychiatric Medication Prescriber: Click or tap here to enter text. Clinic: Click or tap here to enter text. Phone: Click or tap here to enter text. Is the provider aware of this referral? ☐ Yes ☐ No In support of referral? ☐ Yes ☐ No Click or tap here to enter text.

Therapist: Click or tap here to enter text. Clinic: Click or tap here to enter text. Phone: Click or tap here to enter text. Is therapist aware of this referral? ☐Yes ☐ No In support of referral? ☐Yes ☐ No Click or tap here to enter text.

SUD Treatment ☐ Click or tap here to enter text. Sex Offender Treatment Program ☐ Click or tap here to enter text.

County Social Worker/MH Case Manager ☐ Click or tap here to enter text.

Home Health Care ☐

Primary Provider ☐ Click or tap here to enter text. Clinic Phone

ARMHS ☐

Guardian/Conservator ☐

Protective Payee ☐

August 2018

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Housing Services: ☐ Last service date: Click or tap here to enter text. Contact: Click or tap here to enter text.

Mobile Crisis services: ☐ Last service date: Click or tap here to enter text.

Other: Click or tap here to enter text. Phone: Click or tap here to enter text.

Other: Click or tap here to enter text. Phone: Click or tap here to enter text.

Diagnosis

Latest Diagnostic Assessment: Click or tap here to enter text. Completed by: Click or tap here to enter text.

	Diagnostic Code	Diagnosis
Primary Diagnosis:	Click or tap here to enter text.	
Provisional:	Click or tap here to enter text.	
Provisional:	Click or tap here to enter text.	
Provisional:	Click or tap here to enter text.	

Medical Information

Current Medications: Click or tap here to enter text.

Pharmacy: Click or tap here to enter text.

Current Living Situation: Click or tap here to enter text.

Support Services Not Funded: Click or tap here to enter text.

Current Income Source:

Is the Recipient under a civil commitment? ☐ SUD ☐ MH ☐ Both Expiration Date:

The supporting documentation is needed for eligibility. Please check all that is included:

☐ Release of Information for all information included

☐ Documentation of serious mental illness

☐ Functional assessment

☐ Diagnostic assessment

☐ Other pertinent clinical assessments

☐ ICSP Plan (most recent)

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Eligibility Criteria

An eligible ACT service recipient is an individual who:

(Please check all that apply)

☐ Is 17 years of age or older

Has a **primary** diagnosis of:

☐ Schizophrenia-Provider and Date: Click or tap here to enter text.

☐ Schizoaffective disorder-Provider and Date: Click or tap here to enter text.

☐ Other psychotic disorders (please specify) Click or tap here to enter text.

☐ Bipolar Disorder I ☐ Bipolar Disorder II Specifiers: Click or tap here to enter text.

☐ Major depressive disorder with psychotic features Click or tap here to enter text.

Experiences significant functional impairments as demonstrated by at least one of the following conditions. Please check all that apply:

☐ Inability to consistently perform activities daily living. Describe: Click or tap here to enter text.

☐ Inability to remain employed or volunteer at a self-sustaining level. Describe: Click or tap here to enter text.

☐ Inability to maintain a safe living situation. Describe: Click or tap here to enter text.

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); Click or tap here to enter text.

☐ Substance Use Disorder of six months or more in duration Click or tap here to enter text.

☐ Significant independent living instability Click or tap here to enter text.

☐ Homelessness Click or tap here to enter text.

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☐ Very frequent use of mental health and related services that result in poor outcome Click or tap here to enter text.

☐ Repeated criminal justice/legal involvement despite mental health intervention Click or tap here to enter text.

☐ 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 Click or tap here to enter text.

☐ Reside within a 30 mile radius of the city of Bemidji area Click or tap here to enter text.

ACT Referral Process

This referral form and any supporting documentation can be sent via the following ways:

- Fax: (218) 444-5491 Attn: David Berg
- Direct Secure messaging within procentive: tarar2016@ummhc.hdirect.net.
- Outlook Email: [secure] needs to be in the subject line david.b.berg@sanfordhealth.org.
- Sanford Behavioral Health Personnel-please bring to the Clinical staffing meeting on Wednesdays.
- Drop off at 116 3rd St. NW, Bemidji, MN 56601
- Mailing Address: 116 3rd St. NW, Bemidji, MN 56601

It is essential to the eligibility determination process to gather as much current and past clinical information along with this referral to safeguard against inappropriate admissions.

Supportive documentation helps ensure that potential clients and current treatment providers are fully informed of ACT Treatment services provided within our program.

Once referral information including supporting documentation 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 contact David Berg, MA, LMFT, LADC @ 218-333-2217 of david.b.berg@sanfordhealth.org. Thank you for your referral.