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: _____ County of Financial Responsibility: _____

Recipient Name: _____ County of Residence: _____

Phone: _____ Date of Birth: _____

Primary Address: _____

Primary Insurance: _____

Secondary Insurance: _____

Referral Source: _____ Referent's contact: _____

Referents Email: _____ Cadi Waiver? ☐Yes ☐ No

Reason for Referral (details are helpful): _____

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

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: _____ Clinic: _____ Phone: _____
Is the provider 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 _____

SUD Treatment ☐ _____ Sex Offender Treatment Program ☐ _____

County Social Worker/MH Case Manager ☐ _____

Home Health Care ☐

Primary Provider ☐ _____ Clinic Phone _____

ARMHS ☐

Guardian/Conservator ☐

Protective Payee ☐

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Housing Services: ☐ Last service date: _____Contact: _____

Mobile Crisis services: ☐ Last service date: _____

Other: _____ Phone: _____

Other: _____ Phone: _____

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:		
Provisional:		
Provisional:		
Provisional:		

Medical Information

Current Medications: _____

Pharmacy: _____

Current Living Situation: _____

Support Services Not Funded: _____

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)

August 2018

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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: _____

☐ Schizoaffective disorder-Provider and Date: _____

☐ Other psychotic disorders (please specify) _____

☐ Bipolar Disorder I ☐ Bipolar Disorder II Specifiers: _____

☐ Major depressive disorder with psychotic features _____

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: _____

☐ Inability to remain employed or volunteer at a self-sustaining level. Describe: _____

☐ Inability to maintain a safe living situation. Describe: _____

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); _____

☐ 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 outcome _____

☐ Repeated criminal justice/legal involvement despite mental health intervention _____

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☐ 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 within a 30 mile radius of the city of Bemidji area _____

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.