Assertive Community Treatment (ACT) and Intensive Case Management (ICM) Referral Form

CareOregon

Instructions: Please complete all fields below as indicated.

Select the appropriate level of care and attach relevant clinical documentation.

UM submission to CareOregon:

1. via CIM portal (preferred) with completed form and clinicals.
2. via fax – send the completed form and clinicals to 503-416-3713.

Member Client Information

Name: _____

CareOregon Behavioral Health eligibility: ☐ Yes ☐ No

Health Share member: ☐ Yes ☐ No

Pending Health Share member: ☐ Yes ☐ No

Client phone: _____

Member Address: _____

OHP ID: _____ Birth date: _____

Comments: _____

_____

Provider Information

Referring provider agency: _____

Primary contact: _____

Phone: _____ Email: _____ Fax: _____

Preferred provider: _____

*Please note, that all new requests will be entered in as **Provider TBD** and will be updated by the Single Point of Contact (SPOC) when a team is identified.*

Authorization request date: _____

Authorization Request Type

◯ **ACT/**Assertive Community Treatment (if referral is to a specific program, select options below).

- ☐ Referral to FACT
- ☐ Referral to Outside In
- ☐ Referral to NARA for culturally specific services

◯ **Level D Adult/ICM**

- ☐ Referral to IDDT (integrated dual diagnosis)
- ☐ Referral to Waitlist Reduction Team

Authorization specifics

◯ **Initial authorization number:** _____

◯ **Continued stay?** (enter original authorization number): _____

☐ **Dual Authorization Request**
(Request for an additional primary auth. This is not common but can be used for transition or to support clinical needs that the ACT or ICM team does not, or when the added value of a second provider is demonstrated.)

If checked, please answer the following:

1. Justification for dual authorization:

_____

2. Has coordination occurred with the other provider involved?: ☐ Yes ☐ No

   Comments:

_____

3. Is the member aware of the request?: ☐ Yes ☐ No

   Comments:

_____

Documentation

Please include the following documentation with every authorization request:

☐ **Current and valid assessment that includes:**

- Clinical justification for the DSM 5 diagnosis that is a covered diagnosis on Oregon's prioritized list.
- Explanation of the medical need for the services.

☐ **30 days of progress notes**

☐ **Current medication list**

☐ **Recent Psychiatric Medical Provider/medication management notes**

***For FACT:**

☐ LS/CMI report within the past 6 months, if available

***For Outside In/RISE:**

☐ Eligibility for Multnomah County Homeless Youth Continuum (18-24 years old) and experiencing homelessness

***For NARA**

☐ Culturally specific provider serving members who identify as American Indian/Alaska Native

Clinical Information

Reason for referral (include description of functional impairments).

What are the needs that cannot be met at the client's current or most recent outpatient level of care?
How will ACT or ICM services help to support those needs?

Are there cultural or linguistic specific needs when considering placement to a team?

Clinical Information, continued

Current prescriber: _____ Phone: _____

Current diagnosis(es) (indicate primary):

_____

Previous diagnoses: _____

PCP: _____ Phone: _____

Known medical conditions:

_____

Current medications (psychiatric & medical):

_____

Medication dispense (from where and how often?): _____

Risk Assessment

Is there a recent START completed? (Short Term Assessment of Risk and Treatability) ☐ Yes ☐ No
if yes, please include in documentation.

Current level of risk: ◯ Low ◯ Moderate ◯ High

Prominent risk features: suicide attempts, self-harm, harm to others (date, precipitating event, outcome):

_____

Acute Care Admissions

Facility	Dates	Length of Stay	Reason for Hospitalization	Voluntary or Involuntary
				◯ Voluntary ◯ Involuntary
				◯ Voluntary ◯ Involuntary
				◯ Voluntary ◯ Involuntary
				◯ Voluntary ◯ Involuntary

Most recent ER Visits/Hospital Holds/Civil Commitment (date, location, reason, outcome)

Housing Status

Is the client currently houseless?: ☐ Yes ☐ No

Do they meet the HUD definition of "homelessness"?: ☐ Yes ☐ No

If they are houseless, what has been tried?:

_____

Income: _____ Source: _____

Contacts/Supports

Care Coordination/ENCC contact: _____

Payee: _____ PO: _____

Family: _____Landlord: _____

Other: _____

Other: _____

Legal Involvement (police contacts, arrests, bookings, incarcerations)