



Alliance Healthcare Services
Assertive Community Treatment (ACT) Team Referral

ACT is a multi-disciplinary community-based team, located at 1210 Peabody Avenue. The goal of the ACT team is to complete community visits on adult clients with SPMI who are not appropriate for standard outpatient services. The ACT team provides therapy, group, care coordination, peer support, employment support, medication management, and substance abuse treatment services. Once ACT completes their comprehensive assessment of the individual and determines the appropriateness, they will assume all mental health treatment for the client unless additional services are indicated. Please complete the referral form in its entirety (contact information must be included or the referral will not be considered). A member of the ACT team will follow up with you once the referral has been received. They will also reach back out to let you know of the decision to accept or decline the referral. All referrals will be closed out if contact is not secured within 30 days and you will be alerted if that occurs. You may re-refer in the future if you are able to contact the client again and feel they are still appropriate for ACT.

Date: _____ Person/Agency Making the Referral: _____

Reason for Referral: _____

Last Date of Contact/Engagement with Individual Referred: _____ Any Safety Concerns? ☐ Yes ☐ No

Information on Individual Referred

Name: _____ DOB: _____ Age (*must be 18 or older*): _____

Credible Chart ID Number: _____ Date of Last Intake _____ or ☐ Client Needs an Intake

Social Security Number: _____ Sex: _____ Insurance: _____

Phone Number: _____ Email Address: _____

Alternate Phone Number: _____ Physical Address: _____

Has the Referral Been Discussed with the Individual? ☐ Yes ☐ No

Is the client engaged in OP or a grant program? ☐ Yes ☐ No If yes, which clinic or program? _____

Do They Consent to Clinic Visits up to Two Times per Week? (Telehealth may be an option) ☐ Yes ☐ No

Select all that apply:

- ☐ Primary diagnosis of SPMI (Bipolar, Schizophrenia, Major Depressive Disorder, etc.)
- ☐ Persistent and severe symptoms (affective, psychosis, suicidal ideation, etc.)
- ☐ Co-occurring mental illness and substance use disorders
- ☐ Difficulty with traditional outpatient services (therapy, care coordination, etc.)
- ☐ Two psychiatric hospitalizations in the past 12 months or lengths of stay totaling over 30 days in the past 12 months
- ☐ High risk or recent history of criminal justice involvement (frequent contact with law enforcement, incarcerations, etc.)
- ☐ Literally homeless, imminent risk of being homeless, or residing in unsafe housing

Please email this referral to Eli Allen, ellen@alliance-hs.org or Ty Davis, adavis1@alliance-hs.org

For ACT Team:

Date Referral Received: _____ ☐ Referral Source Contacted Referral Accepted: ☐ Yes ☐ No

If no, why: _____ ☐ Referral Closed due to Lack of Contact Date Referral Source Contacted re: Status: _____