# Family & Children's Center Youth Assertive Community Treatment Referral & Screening Form

Name of Recipient:_______________________________________________

County of Residence:______________________ Date of Referral:_____________

County of Financial Responsibility______________ Date of Birth:______________

Legal Address:__________________________ Phone Number:_____________

Social Security #:________________________ MA?:Yes_______ No________

MA #:_______________________________ MA Type:________________

Insurance Name:________________________ GRP#:___________________

Policy #:______________________________

Person Making Referral:____________________ Referent's Phone #:___________

If under 18, Name of Parents:________________________________________

Contact number for Parents:_________________________________________

_______________________________________________________________

Reason for
Referral:_______________________________________________________

_______________________________________________________________

_______________________________________________________________

Is client aware and in support of this referral: ☐ Yes ☐ No

Most recent DA Date:______________ Completed by:______________________

Diagnosis on most recent DA: DSM V Diagnosis_______________________________________

| Axis I |
|---|
| Axis II |
| Axis III |
| Axis IV ☐ Primary Support Group ☐ Social Environment ☐ Education ☐ Occupation ☐ Housing ☐ Economic Problems ☐ Access to Health Care ☐ Interaction with legal system ☐ Other |
| Axis V Current GAF_______ Highest Past Year________ SED ☐ Yes ☐ No SPMI ☐ Yes ☐ No Date______ |

Current Living Situation:

Funding: GRH ☐ CADI ☐ Other (Specify):

Current Sources of Income:

Under Civil Commitment? No ☐ Yes ☐

Please include the following information that is applicable with the referral:

-Release of Information
-Documentation of serious mental illness or co-occurring mental illness and substance abuse addiction
-Current assessments
-Other treatment information (i.e. mental health treatment, medical treatment, education, housing)
-Crisis Plan
-Information regarding criminal history
-Guardian/Conservatorship

*To be eligible for Youth ACT services, individuals must meet all of the following:*

-Be 16, 17, 18, 19, 20 years old

**And**

-Diagnosed with a serious mental illness or co-occurring mental illness and substance abuse addiction requiring intensive nonresidential rehabilitative mental health services

**And**

-Has received a level of care determination using the CASII that indicates need for intensive intervention without 24 hour medical monitoring.

**And**

-Has a functional impairment and a history of difficulty in functioning safely and successfully in the community, school, home or job; or who is likely to need services from the adult mental health system within the next two years.

**And**

-Has had a recent diagnostic assessment, as provided in Minnesota Rules, part 9505.0372, subpart 1, by a mental health professional who is qualified under Minnesota Rules, part 9505.0371, subpart5, item A, that documents that intensive nonresidential rehabilitative mental health services are medically necessary.

*Checklist of required documentation:*
_____ Release of information signed
_____ Most recent Diagnostic Assessment
_____ List of current medications, including dosages, and administration times
_____ Recent notes, summaries, discharge papers from doctors, therapist, hospitals
Please send referral form and other information to:

Family & Children's Center
ATTN: Youth ACT Team
601 Franklin St.
Winona, MN 55987

Phone: 507-453-9563 ext. 1140
Fax: 507-453-9562

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*To be completed by Youth ACT team*

☐ Client will be opened with Youth ACT services

☐ Client will not be opened with Youth ACT services, Reason___________________________________

Mental Health Professional's Signature: _______________________________________Date:_________