



Referral & Admissions Criteria
Assertive Community Treatment (ACT)

Please choose the ACT service location you'd like the referral to be sent to:

- | | |
|--|---|
| <input type="checkbox"/> 235 Civic Center Blvd., Houma, LA 70360 | <input type="checkbox"/> 312 E. Bayou Road, Thibodaux, LA 70301 |
| <input type="checkbox"/> 400 N. Rampart St, New Orleans, LA 70112 | <input type="checkbox"/> 2150 General Pershing Street, Mandeville, LA 70448 |
| <input type="checkbox"/> 153 N. 17th Street, Baton Rouge, LA 70802 | |

Participant Name:		DOB:	Date:
Primary Phone Number:		Alternative Number:	
Home Address:			
City/State:		Zip Code:	
Has Medicaid? <input type="checkbox"/> YES <input type="checkbox"/> NO	Verified: <input type="checkbox"/> YES <input type="checkbox"/> NO	Medicaid Number:	
Bayou Health Plan:		Other Insurance/Medicare:	
Referral Source			
Referral Source Name:		Referral Completed by:	
Contact Number:		Email:	
Referral Information			
Reason for Referral:			
Psychiatric Diagnoses:			
Current Medications:			
History of Psychiatric Hospitalization:			
Any current legal charges:			
Additional Comments:			

Referral packet can be emailed to actreferrals@startcorp.org or faxed to (225) 377-4197

Referent, please fill out the following:

Participant Name:	Date:
DIAGNOSIS	
<i>The individual must have one of the following diagnoses:</i>	
<input type="checkbox"/> Schizophrenia <input type="checkbox"/> Schizoaffective Disorder <input type="checkbox"/> Bipolar Disorder <input type="checkbox"/> Major Depressive Disorder <input type="checkbox"/> Other psychotic disorder: _____	
<i>These diagnoses are also accompanied by:</i>	
<input type="checkbox"/> Substance Use Disorder <input type="checkbox"/> Developmental Disability	
SERVICE NEEDS	
<i>The individual must have one or more of the following:</i>	
<input type="checkbox"/> Two or more acute psychiatric hospitalizations and/or four or more Emergency Room visits in the last 6 months <input type="checkbox"/> Persistent and severe symptoms of a psychiatric disability that interferes with the ability to function in daily life <input type="checkbox"/> Two or more interactions with law enforcement in the past year for emergency services due to mental illness or substance use (this includes involuntary commitment) <input type="checkbox"/> Currently residing in an inpatient bed, but clinically assessed to be able to live in a more independent situation if intensive services were provided.	
<i>The individual must have one or more of the following:</i>	
<input type="checkbox"/> Inability to participate or remain engaged or respond to traditional community-based services <input type="checkbox"/> Inability to meet basic survival needs or residing in substandard housing, homeless, or is at imminent risk of becoming homeless	
<i>The individual must have three of the following:</i>	
<input type="checkbox"/> Evidence of a co-existing mental illness and substance abuse / dependence <input type="checkbox"/> Significant suicidal ideation with a plan and ability to carry out within the last two years <input type="checkbox"/> Suicide attempt in the last two years <input type="checkbox"/> History of violence due to untreated mental illness / substance abuse within the last two years <input type="checkbox"/> Lack of support systems <input type="checkbox"/> History of inadequate follow-through with community-based services <input type="checkbox"/> Threats of harm to others in the past two years <input type="checkbox"/> History of significant psychotic symptomatology such as command hallucinations to harm others	
Additional Information:	

Referral Source (Print Name)

Referral Source (Signature)

Date

Referral packet can be emailed to actreferrals@startcorp.org or faxed to (225) 377-4197