Youth ACT Referral Form & Screening Tool

RADIAS HEALTH
Welcome to a full circle of care.

Date of Referral:

Name: ***Gender & Pronouns:***	***Phone:***
Date of Birth: *(must be 14-20 to be eligible)*	***Social Security #:***

Is the person aware you're making this referral? ☐ Yes ☐ No- If no, how can we best coordinate?

How does the person feel about being referred? ☐ Agreeable ☐ Uncertain ☐ Uninterested - engagement needed

Primary Language/Interpreter needs:

Home Address:

Current location if other than home:

County of Residence:

Parent or Guardian Name:

Address:

Phone:

Individuals typically need to be open with Medicaid (straight MA or PMAP) to be enrolled in ACT. Please note any known barriers or delays to active enrollment.

MA Number

If PMAP, note Health Plan: ***Other insurance information:***

Referring Party Name / Agency:

Email: **Phone:**

Diagnosis: Include descriptions and codes. Indicate which is primary. Priority given to psychotic and mood disorders.

Reason for referring to Youth ACT (why is this service level needed, how do you hope it will help the person):

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Current Providers (Name / Agency / Phone) and Relevant Information:

Psychiatrist:

Other providers:Therapy,ARMHS, CADI, TCM, etc.):

Supervising Probation Agent:
Name **Email:** **Phone:**

Current sources of income: ☐ **SSI /** ☐ **SSDI-RSDI /** ☐ **MFIP /** ☐ **Employment /** ☐ **Other:**
Current medication (attach if possible):

Family Support – Is the family willing to be involved in treatment?

What other treatment approaches have been tried?

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Is the youth under civil commitment: ☐ Yes ☐ No

If yes, type and date of expiration. (please include court order with referral)

Recurrent difficulty in the following functional areas of: (check all that apply):

☐ Interpersonal Relationships
☐ Medical/Dental
☐ Recognizing and avoiding common dangers
☐ Meeting nutritional needs
☐ Maintaining personal hygiene
☐ Benefit/income management
☐ Medication adherence
☐ Educational/Vocational
☐ Sexual health
☐ Social/Recreational
☐ Housing (homeless, runaway)
☐ Accessing community resources/social support systems
☐ Persistent or recurrent difficulty in multiple functional areas (as listed in the preceding question) without significant assistance from others (friends, family or relatives).
☐ The individual is residing in substandard housing, is homeless, or at imminent risk of becoming homeless. Specify: The individual has been unable to obtain/maintain consistent employment and/or role as a student Specify:
☐ Other pertinent information:

Priority will be given to individuals who meet <u>at least one</u> of the following criteria

☐ Youth with emerging psychosis, thought disorder, or mood disorder
☐ High utilization of psychiatric hospitals or emergency psychiatric services. Specify approximate # of admissions over the past two years: ☐ Inpatient #/days: ___ / ___ / ☐ ED#: ___ / ☐ Crisis #: ___ / ☐ Detox #: ___

If available, include the following records. If not available, we may need to work with you and the individual to get records before making an eligibility determination.

☐ Diagnostic Assessment (within one year)	☐ Current and Historical Hospitalization Records / Dates	☐ Civil Commitment / Prepetition paperwork (current / historical)
☐ Functional Assessment	☐ LOCUS/CASII	☐ MH professional - statement of need

Please either fax or send referrals via secure email to our Central access Team. You will be contacted within 24 business hours to determine the next steps. We are happy to consult prior to referral.

Fax	Email	Phone
651-677-5714	centralaccess@radiashealth.org	612-453-4010