Comprehensive Life Resources PACT Referral Form

We want to thank you for the referral of your client, friend, or family member to PACT for intensive community treatment services.

PACT is a community-based team that provides intensive community-based treatment with adults who have severe and persistent co-occurring mental health disorders. Our team provides wrap around care that includes: Psychiatric Provider, Registered Nurse, Licensed Mental Health Counselor/Social Worker, SUD Counselor, Vocational Specialist, Psychiatric Rehabilitation and Peer Support. PACT is a voluntary treatment program that is custom tailored to meet the needs of clients that have not found success working with traditional treatment programs.

To qualify for the PACT program, the client must reside in Pierce County and have:

- *Primary diagnoses of schizophrenia or other psychotic disorder such as Bipolar Disorder.*
- *Major functional impairment such as being unable to live independently, difficulties maintaining ADL's and/or meeting criteria for grave disability.*
- *Problems using traditional office based mental health services*

AND at least two of the following:

- *Two psychiatric hospitalizations in the past 12 months (depending on where they were hospitalized)*
- *Symptoms are persistent and recurrent*
- *Recent history of criminal justice involvement (frequent contact with law enforcement, incarcerations, and/or supervision)*
- *Homeless or at imminent risk of homelessness, or residing in unsafe/unstable housing*
- *A co-occurring disorder has been present for at least 6 months*
- *Living in an inpatient facility (Telecare, Western State Hospital, SSBH), but could live more independently if intensive services were provided.*

Note: PACT does not work well for clients where the primary diagnosis is a personality disorder, substance use, or developmental disability.

If at any point in this process you have a question or concern about the PACT program, the intake process or plans for community living, please feel free to call the 253-396-5800, and ask to be transferred to the PACT Team Lead, Lara Hatch. We can be reached during regular business house or feel free to leave a voice message and a PACT team member will get back to you.

Respectfully,

The CLR PACT Team

Program for Assertive Community Treatment (PACT)
Referral Request Form

Referral Information

Referral Date:	Referring Individual:
Have PACT Services been discussed with the client? ☐Yes ☐ No If so, how open are they to the program? If not, why?	Agency/Job Title:
	Phone number:
	Email:

Client Information

Client Name:	Client DOB (must be over 18):
Client Address:	Client phone number:
What kind of insurance does the client have: ☐ Medicaid ☐ Medicare ☐Spenddown (Amount $_______) ☐No Insurance ☐ Private Insurance (Type: ____________)	

Clinical Information

Eligibility: Please note, to be eligible for PACT an individual must have a primary diagnosis of a severe and persistent mental illness. Eligible diagnoses include schizophrenia, schizoaffective disorder, other psychotic disorders, and mood disorders (bipolar/depression) with psychotic features, with demonstrated need for intensive support.

Does the individual being referred have an existing mental health diagnosis? ☐ Yes ☐ No Please list any known diagnoses:
Diagnosis 1:
Diagnosis 2:
Diagnosis 3:

Clinical Info Cont.

Does the individual being referred have a substance use disorder? ☐ Yes ☐ No
If yes, what substances do they use and what stage of recovery (actively using, in recovery) are they in? (*PACT provides services for all stages of recovery*):

Does the client have a personality disorder; either documented or suspected? (*PACT cannot accept those with a personality disorder due to the program not being conducive to their recovery*): ☐Yes ☐ No

Does the client have a developmental disability? ☐Yes ☐ No

Does the client have any medical issues? If so, please list primary concerns and Primary Care Doctor if available:

Service History:

Eligibility: Continuous high-service needs due to mental illness demonstrated by the following: (please check all that apply and explain in narrative below under More Info)

- ☐ High use of acute psychiatric hospitals (i.e. 2 or more admissions per year or psychiatric emergency services.)
- ☐ Intractable (i.e. persistent of very recurrent) and severe symptoms (i.e. psychotic, manic, suicidal). Identify major symptoms:
- ☐ Co-Occurring Substance Use disorder of significant duration (longer than 6 months).
  Client's Drug of choice:
  Duration of use:
- ☐ Significant difficulty meeting basic survival needs or residing in substandard housing
- ☐ At risk of becoming homeless
- ☐ Is individual chronically homeless?
  What are barriers to obtaining housing?:
  Number of episodes of homelessness in the last 5 years and when:
- ☐ Residing in an inpatient or supervised community residence, but clinically assessed to be able to live in a more independent living situation if intensive services are provided.
- ☐ Difficulty effectively utilizing traditional office-based outpatient services or other less intensive community based programs (i.e. consumer fails to progress, drops out of services)

More information:

Is the individual already receiving services for mental health? ☐ Yes☐ No **If yes, where?**		
Where has the individual received mental health/substance use treatment in the past?:		
Program/Agency	**Estimated Dates**	**Reason for treatment**

Hospitalization History:

Eligibility: Two psychiatric hospitalizations in the past 12 months. Not meeting this criteria is not an immediate disqualifier

Hospital	Admitting Reason	ITA? (Y or N)	Dates

Incarceration History:
Eligibility: High risk or recent history of criminal justice involvement (frequent contact with law enforcement, incarcerations, and/or supervision)
All known incarcerations, arrests or other law enforcement contacts, with details as available:

Correctional Facility	Charge/Reason for Contact	Approx dates

Functional Impairments:
Eligibility: The individual experiences significant functional impairments due to mental illness as demonstrated by the following conditions

☐Significant difficulty maintaining consistent employment at a self-sustaining level.

☐Significant difficulty with consistently performing the range of practical daily living skills required for basic adult functioning in the community (i.e. having and following through with medical care, recognizing and avoiding common dangers or hazards to self and possessions, meeting nutritional needs, maintaining personal hygiene)

☐ Persistent or recurrent difficulties performing daily living tasks except with significant support or assistance from others such as friends, family or relatives.

☐ Significant difficulty maintaining a safe living situation (i.e. repeatedly forgetting to turn stove burners off, consistent unsanitary conditions due to uncollected garbage, food scraps)

☐ Other significant difficulties:

In general, services that PACT provides are the following (please check those that you and your client would like to be included in a treatment plan)	**Client Requests**	**Referral Source Requests**
Assistance with Medical/Dental Care	☐	☐
Assistance with Medication Management	☐	☐
Assistance with Daily living skills (i.e shopping, hygiene, cooking, etc)	☐	☐
Assistance with Money Management	☐	☐
Assistance with Employment/Education	☐	☐
Assistance with Mental health Therapy/Counseling	☐	☐
Assistance with Cultural Differences	☐	☐
Assistance with Social Skills	☐	☐
Assistance with Transportation to medical appointments and/or grocery shopping	☐	☐
Assistance with reducing/stopping Drugs/Alcohol/Smoking	☐	☐
Assistance with Leisure Activities (Hobbies/Skills)	☐	☐
Assistance Connecting/Reuniting with Family/Supports	☐	☐

Additional information:

Guardian (if applicable, provide copy court order):
Payee:
Mental Health or Medical Advance Directive (Provide copy):☐ Yes ☐ No

Please Fax the following information with the referral form, if available:**

☐Mental Health Assessment
☐List of current medications (MAR if available, but not necessary)
☐Current Chart notes, including psychiatric, for the past month
☐Release of information for Behavioral Health Resources

Return completed referral to: Arquelle Williams, Attention: "PACT Referral."

(for CLR employees, send via internal email, for outside agencies,

please fax to 253-383-5548)

For any questions about the referral form or to consult about whether a client is appropriate, prior to completing this form, feel free to contact the PACT Team 253-396-5016 with any questions
*****Please note that if this referral is coming from an agency that provides mental health services the referral will not be considered until all needed information is provided.***