County of San Diego HHSA Adult/Older Adult Behavioral Health Services
ASSERTIVE COMMUNITY TREATMENT (ACT)
FOR HOMELESS PERSONS WITH SEVERE MENTAL ILLNESS
REFERRAL FORM

*** Hover the pointer over the program title, right click the mouse and select "Open Hyperlink" for more information. ***

REFERRAL TO ASSERTIVE COMMUNITY TREATMENT (ACT) PROGRAMS

- ☐ Community Research Foundation Adelante (South): (619)934-5770; mailto:AdelanteReferrals@comresearch.org
- ☐ Community Research Foundation Downtown IMPACT (Central): (619) 398-2156; mailto:DowntownImpactReferrals@comresearch.org
- ☐ Community Research Foundation IMPACT (Central/North Central): (619) 398-0355; mailto:ImpactReferrals@comresearch.org
- ☐ Community Research Foundation Senior IMPACT (Countywide): (619) 977-3716;mailto:SeniorImpactReferrals@comresearch.org
- ☐ Mental Health Systems (MHS) Center Star ACT (Countywide): (619) 521-1743; mailto:CenterStarACT.referrals@mhsinc.org
- ☐ Mental Health Systems (MHS) City Star ACT (Central/North Central): (858) 609-8742; mailto:CityStarACT.referrals@mhsinc.org
- ☐ Mental Health Systems (MHS) North Coastal ACT (North): (760) 290-8170; mailto:NorthCoastalACT.referrals@mhsinc.org
- ☐ Mental Health Systems (MHS) North Star ACT (North): (760) 432-9884; mailto:NorthStarACT.referrals@mhsinc.org
- ☐ Pathways Catalyst ACT (Countywide): (858) 300-0460; mailto:PTW_CA_SAN2_CatalystReferrals@pathways.com

REFERRAL TO ASSERTIVE COMMUNITY TREATMENT - SUBSTANCE ABUSE TREATMENT PROGRAMS (Dual Track Programs)

- ☐ Mental Health Systems (MHS) ACTION Central: (619) 287-8225; mailto:ActionCentralACT.referrals@mhsinc.org mailto:ActionCentralSUD.referrals@mhsinc.org
- ☐ Mental Health Systems (MHS) ACTION East: (619) 383-6868; mailto:ActionEastACT.referrals@mhsinc.org mailto:ActionEastSUD.referrals@mhsinc.org

REFERRING PARTY INFORMATION

Date of Referral: Name of Person Making Referral:

Email of Referring Party, if available*:

Referring Agency: Address:

Phone: Fax:

*If choosing to communicate via email, please ensure compliance to Article 14 and confidentiality requirements. Email may be used between providers and referring parties as long as no client information is included unless encryption is used. This referral form should never be sent via email unless encrypted.

IDENTIFYING INFORMATION OF PERSON BEING REFERRED

Name: SS# (Last 4 ONLY): DOB: Language of Preference: Age: MIS#:

Aliases: Gender: Ethnicity:

Address: Phone:

Has he/she ever been Homeless? ☐YES ☐NO Period of Homelessness:

Is he/she connected to Whole Person Wellness? ☐ YES ☐ NO

Alternate Telephone Number or Other Supports: Relation: Phone:

CLINICAL INFORMATION

Is Person Interested in Case Management? ☐ YES ☐ NO Provide Specific Reason(s) for Referral:

Current Problems, Barriers, Challenges, OR Problems When Person is Not Stable:

Mental Health Stage of Recovery: ☐ Pre-Contemplation ☐ Contemplation ☐ Preparation ☐ Action ☐ Maintenance ☐ Relapse

History of Mental Health Treatment:

Number of Psych Hospitalizations in the past year: Reasons:

Does Person Have Problematic Use of Substances? ☐ YES ☐ NO Date of Last Use:

Substance(s) of Choice:

Substance Use Stage of Recovery: ☐ Pre-Contemplation ☐ Contemplation ☐ Preparation ☐ Action ☐ Maintenance ☐ Relapse

History of Drug/Alcohol or Co-Occurring Treatment:

Risk for Harm or Dangerous Propensities (e.g., Suicide Attempts, SI, HI, Command AH, Hx of Violence, Threats, Risky Behavior):

Current Impairments in Daily Functioning:

Goals, Strengths, and Interests:

CULTURAL FACTORS RELATED TO MENTAL HEALTH:

DIAGNOSES

Primary:

Secondary:

Other(s):

Medical condition(s) important to the understanding or management of an individual's mental disorder(s):

Psychosocial and contextual factors (use V&Z codes most relevant to the mental disorder):

CURRENT MEDICATIONS:

Current Treating Psychiatrist: Phone:

CURRENT MEDICAL ISSUES:

Primary Care Physician: Phone:

LEGAL INFORMATION

Is Person Conserved? ☐ YES ☐ NO Name of Conservator: Phone:

Has Person been Incarcerated or Had Legal Issues? ☐ YES ☐ NO If yes, please explain:

Person is on ☐ Parole ☐ Probation Parole/Probation Officer: Phone:

Other Pertinent Legal Information or Restrictions:

FINANCIAL / INSURANCE INFORMATION

Current Source of Income: ☐ SSI ☐ SSDI ☐ SDI ☐ WORK ☐ NONE ☐ Other:

Payee: Phone:

Current Insurance Status: ☐ Medi-Cal ☐ Medicare ☐ VA ☐ Indigent

Medi-Cal #: Medicare #:

Private/Other Insurance Information:	Policy #:	Phone:
Signature of Person Completing Referral:_____		Date:

This electronic form can also be found in the Technical Resource Library (TRL).