Assertive Community Treatment (ACT) and Intensive Case Management (ICM) Referral Form

CareOregon

Instructions: Please complete all fields below as indicated. Select the appropriate level of care and attach relevant clinical documentation, along with any additional information that will not fit on the form.

UM submission to CareOregon:

1. via CIM portal (preferred) with completed form and clinicals.
2. via fax – send the completed form and clinicals to **503-416-3713**.

Member Client Information

Name: _____

Preferred name: _____

Pronouns: _____ Gender identity: _____

Member Address: _____

Client phone: _____

Health Share member: ☐ Yes ☐ No Pending Health Share member: ☐ Yes ☐ No

OHP ID: _____ Birth date: _____

Race

☐ American Indian/Indigenous/Native American or Alaskan Native*

☐ _____

☐ Asian/Pacific Islander

☐ _____

☐ Black/African American

☐ _____

☐ Eastern European/Russian

☐ _____

☐ Native Hawaiian

☐ _____

Some other race, ethnicity, or origin

☐ White/Caucasian

☐ _____

☐ Chose not to answer

☐ Not provided

☐ Unknown

Continued

Ethnicity:

Hispanic, Latino/a/x/e or of Spanish origin

- ☐ Mexican, Mexican American, Chicano/a/x/e
- ☐ Puerto Rican
- ☐ Cuban
- ☐ Other Hispanic, Latino/a/x/e or Spanish origin
- ☐ Latino/a/x/e combined with racial identities
- ☐ Not Hispanic, Latino/a/x/e or of Spanish origin

Immigrant or Refugee:

☐ Yes ☐ No _____

Cultural, linguistic, and provider gender preference

Are there cultural or linguistic specific needs when considering placement to a team?

○ **Yes** ○ **No** ○ **Unknown**

If yes, please provide summary/details of cultural/linguistic needs for the member and family system as it pertains to treatment and care coordination.

_____

Provider Information

Referring provider agency: _____

Primary contact: _____

Phone: _____ Email: _____ Fax: _____

Preferred provider: _____

Authorization request date: _____

Contacts/supports

Contact/Support	Name	Phone	Email
ENCC			
AICC			
Guardian			
Primary care			
Parole and probation			
Payee			
Family			
Landlord			
Other			

Authorization Request Type

◯ **ACT/**Assertive Community Treatment

◯ **Level D Adult/ICM**

Authorization specifics

☐ **Initial authorization number:** _____

☐ **Continued stay?** (enter original authorization number): _____

Documentation

Please include the following documentation with every authorization request:

☐ Current and valid assessment that includes:

- Clinical justification for the DSM 5 diagnosis that is a covered diagnosis on Oregon's prioritized list.
- Explanation of the medical need for the services.

☐ 30 days of progress notes

☐ Current medication list

☐ Recent Psychiatric Medical Provider/medication management notes

Housing Status

Is the client currently houseless?: ☐ Yes ☐ No

Do they meet the HUD definition of "homelessness"?: ☐ Yes ☐ No

Information about current housing situation or needs:

_____

Income: _____ Source: _____

Clinical Information

Reason for referral (include description of functional impairments).

What are the needs that cannot be met at the client's current or most recent outpatient level of care?
How will ACT or iCM services help to support those needs?

Clinical Information, continued

Current diagnosis(es) (indicate primary):

Current prescriber: _____ Phone: _____

Known medical conditions:

PCP: _____ Phone: _____

Current medications (psychiatric & medical):

Medication dispense (from where and how often?):

Risk Assessment

Current level of risk assessment: ○ Low ○ Moderate ○ High

Prominent risk features: suicide attempts, self-harm, harm to others (date, precipitating event, outcome):

Acute Care Admissions

Facility	Dates	Reason for Hospitalization	Voluntary or Involuntary
			○ Voluntary ○ Involuntary
			○ Voluntary ○ Involuntary
			○ Voluntary ○ Involuntary
			○ Voluntary ○ Involuntary

Most recent ER Visits/Hospital Holds/Civil Commitment/Legal Involvement

(date, location, reason, outcome)