MO – ACT Admission Criteria; Specialized Parent & Child Programs

Diagnosis: (include ICD 10 description and code; indicate principal diagnosis/ include additional diagnosis for all conditions)
See crosswalk document for approved specialized ACT team diagnoses. (Includes all ACT, ACT-TAY and CPR qualifying diagnoses.)

DSM 5 / ICD 10 Diagnoses	
Principal:	Code:_____
Additional:	Code:_____
	Code:_____
	Code:_____
	Code:_____
Functional Assessment: Current mGAF/CGAS_____Highest Past Year _____	

For admission to an Assertive Community Treatment team an individual must have an approved diagnosis and at least one of the following conditions listed below in the last 12 months (check all that apply). **Pregnancy and/or with child up to age 8.**

☐ The person has been recently discharged from an extended stay in a state hospital (e.g., 3 months or more). For transitional age youth (ages 16-25) an extended stay in a residential or post foster care facility.
Name of facility:_____**Length of stay (Months)** _____

☐ High utilization of acute psychiatric hospitals (e.g., 2 or more admissions per year) and/or psychiatric emergency services (e.g., 3 or more per year). **Specify the # of admissions over the past two years**:_____**and/or the # of emergency contacts in the past two years**:_____

☐ Co-existing substance use disorder (Indicate diagnosis above) of significant duration (e.g., greater than 6 months) **Duration (Months)**_____. **What is client's stage of substance use treatment?** _____
_____

☐ Exhibits socially disruptive behavior with high risk of criminal/juvenile justice involvement/Children's Division involvement (e.g., arrest and incarceration). **For the past two years specify the # of arrests**_____**and/or days incarcerated** _____**and/or # of contacts with law enforcement/Children's Division** (hotlines, open case at CD or child in custody) _____

☐ The individual is residing in substandard housing, homeless, or at imminent risk of becoming homeless.
Specify:_____

☐ Exhibits ***serious functional impairments*** as demonstrated by inability to consistently perform the range of practical daily tasks required for basic functioning such as the inability to recognize and avoid common dangers or hazards to self, maintain a safe living situation, maintain personal hygiene, be consistently employed at self-sustaining level, and, for transition age youth, to function adequately in a school setting and/or employment setting.

☐ Experienced early warning signs and/or the symptoms of an initial episode of psychosis, and in the absence of or had it not been for medications or other intensive intervention, it would have led, or did lead, to a significant decrease in overall functioning within the past two years (e.g. hallucinations, delusions or false beliefs, confused thinking or other cognitive difficulties) Estimated # months since initial symptoms started_____.

☐ **Other (describe):**_____

Completed by (Signature):_____Date: _____

I have reviewed the diagnosis, above criteria, and treatment plan and find that treatment continues to be medically necessary, and this client meets the ACT admission criteria as of the above ACT admission date.

QMHP signature/date:_____ Physician Signature/date: _____

Client Name	Record No.