BEECH BROOK

**A Contract Agency of the Alcohol, Drug and Mental Health Services Board**

***PLEASE PRINT OR TYPE***

# TRANSITIONAL YOUTH ACT REFERRAL

| Date: | Referring Agency: | | Date of Admission to Agency: | |
|---|---|---|---|---|
| **Client Name:** | **Date of Birth:** | **Age:** | **SHARES No.** | **UCI No:** |
| | | | | |

**Is Client a legal resident of Cuyahoga County?** ☐ **Yes** ☐ **No**

| **Address:** | **Phone:** |
|---|---|
| | |

**Custody:** ☐ **Self** ☐ **Parent(s)** ☐ **CCDCFS** ☐ **Other:**_____

**Legal Guardian Name:** _____ **Legal Guardian Telephone Number:** _____

**Responsible School District (if applicable):** _____ **Last Grade Completed:** _____

**Name and Type of School/Program Attending:** _____

**Does the client have SSI/SSDI?** ☐ **Yes** ☐ **No**

**If no, has an application been completed?** ☐ **Yes** ☐ **No**

**Further Explanation:**_____

_____

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**<u>Diagnosis (Must have one of the four qualifying primary diagnosis on Axis I)</u>:**

**Axis I:**

**Axis II:**

**Axis III:**

**Axis IV:**

**If the client is diagnosed with a Developmental Disability, is he or she linked with DD Services?** ☐ **Yes** ☐ **No** ☐ **Non-applicable. If Yes or No is checked, please explain below:**

_____

_____

_____

**Client's psychiatric hospitalization/residential treatment/level 4 foster care history during the *<u>past 3 years</u>*.**

| Hospital/Res. Tx. Center/Level 4 Foster Care Program | Month/Year | Length of Stay | Reason for Admission |
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| **The ACT Model was designed for those clients for whom traditional CPST has been unsuccessful in preventing or reducing repeated hospitalizations/residential treatment/level 4 foster care admissions and homelessness. Please give a detailed description of interventions that have been used to engage client in traditional CPST and outcome of the interventions.** |
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| **Are there cultural issues which need to be considered when assigning this person to an ACT Team?** |
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| **Primary language client speaks:** |
| **Describe the client's present living situation:** |
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| **County of current living situation:** |
| **Expected date of discharge from current living situation:** |
| **Does the client have any physical disabilities? ☐ Yes ☐ No. If yes, describe:** |
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| **Does the client have a history of substance abuse? ☐ Yes ☐ No. Currently using? ☐ Yes ☐ No. If yes for either of these questions, describe the types of substances abused e.g. alcohol, marijuana, crack/cocaine, prescription meds, etc. Has the client been involved in any type of substance abuse treatment program, historically or presently? ☐ Yes ☐ No. If yes, please describe treatment received / receiving.** |
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| **Does the client have a forensic status, i.e. has the client been found NGRI (not guilty by reason of insanity) or ISTU (incompetent to stand trial, unrestorable)? ☐ Yes ☐ No. Is the client involved in the MDO (mentally disordered offender) program? ☐ Yes ☐ No. If yes to either of these questions, please specify including client's legal code number:** |
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| **Persons who do not have repeated mental-health-related out-of-home-care placements, but are considered difficult to treat, generally non-responsive to treatment, and at high risk for hospitalization, residential treatment, and/or level 4 foster care will also be considered. If the client meets this criteria, please describe:** |
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| **Rationale for referral to an ACT Team:** |
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| **Is the client agreeable to ACT services?** ☐ **Yes** ☐ **No** |
| **Current medications:**<br><br>**Other:** |

| | |
|---|---|
| **Name and Title of Person Completing this Form:** | **Telephone Number:** |
| **Name and Title of Authorized Supervisor:** | **Telephone Number:** |
| **Print, mail or fax completed referrals to:**<br><br>**Maggie Tolbert**<br>**Utilization Review Specialist**<br>**ADAMHS Board of Cuyahoga County**<br>**2012 West 25th Street, 6rd Floor**<br>**Cleveland, Ohio 44113**<br>**FAX: 216-241-0805** | **ADAMHSCC BOARD USE ONLY:**<br><br>**Date Sent: _____/_____/_____**<br>**Agency:_____**<br>**Date of Acceptance:_____/_____/_____** |

**Print**