Notification of Discontinuation from Assertive Community Treatment

Fax Forms to the Collaborative at: 866-928-7177

Agency: _____	**Name of Referred**: _____
Agency Location:_____	**Date of Birth**: _____
Agency FEIN:_____	**RIN #** _____
Team Name: _____	

Male: ☐ **Female:** ☐

Admit Date to ACT:_____

ACT was discontinued on(date): _____

I. DISCONTINUANCE CRITERIA (Please check only one)

☐ Person requests termination from ACT and is currently stable (complete transition plan for ongoing services)
☐ Person has improved to the extent that ACT is no longer needed and recovery goals have been met and there is no medical necessity for ACT (complete transition plan for ongoing services)
☐ Person has moved out of the ACT teams geographic area and has been linked to the following program
☐ Person has moved out of the State and has been linked to the following services
☐ Person cannot be located, in spite of repeated ACT efforts (Describe efforts to locate and continue ACT services such as number of failed contacts, time elapsed since last contact: lack of leads on whereabouts from the person's emergency contact list.)
☐ Person requests termination from ACT despite the clinical recommendation of the team
☐ Person has been incarcerated
☐ Person is in need of hospitalization that may exceed 90 days
☐ Person is in need of nursing facility level of care that may exceed 90 days
☐ Deceased

II. DIAGNOSIS ON EXIT

DSM Diagnosis ***All 5 Axes must be completed***	**Diagnosis (Code)**	**Rank** **(Please rank diagnoses in Axes 1-3 in order of primacy)**
Axis I		
Axis II		
Axis III		
Axis IV		
Axis V - Global Assessment of Functioning (GAF)	Highest Last Year:	Current:

Agency: _____ **Name of Referred**: _____

Date of Birth: _____ **RIN #** _____

III. LOCUS SCORE AT TIME OF DISCONTINUED SERVICE

Domain Scores: Risk of Harm: _____ **Recovery Environment – Environmental Stressors:** _____

Recovery Environment – Environmental Support: _____ **Functional Status:** _____

Co-morbidity: _____ **Recovery and Treatment History:** _____ **Acceptance and Engagement:** _____

LOCUS score recommended at of service being discontinued **Composite Score:** _____

☐ Level I ☐ Level II ☐ Level III ☐ Level IV ☐ Level V ☐ Level VI

ASSESSOR RECOMMENDED LEVEL OF CARE (according with services crosswalk)

☐ Level I ☐ Level II ☐ Level III ☐ Level IV ☐ Level V ☐ Level VI

Reason for deviation (if Applicable)
Explain:

IV. TRANSITION PLAN – If applicable (NARRATIVE) (Please write legibly.)

Clinical staff to contact with any questions (print) _____

Phone: (_____) _____ Fax Number: (_____) _____

Encrypted email address: _____

Please note that incomplete forms will be returned