The Illinois Mental Health Collaborative for Access and Choice

NOTICE OF DISCONTINUATION FROM ASSERTIVE COMMUNITY TREATMENT SERVICES (ACT)

NOTE: 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:** ☐

Date ACT service started: _____ **Date ACT was discontinued:** _____

PLEASE PRINT *(Must Include)*
Staff to contact with any CLINICAL questions: _____
Phone: _____ **Secure Fax Number:** _____
Encrypted Email Address: _____

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

PRIMARY BEHAVIORAL DIAGNOSIS (DSM-5) ***Required Field**

*Diagnostic Category 1	*Diagnosis Code 1	*Description

ADDITIONAL BEHAVIORAL DIAGNOSIS (DSM-5)

Diagnostic Category 2	Diagnosis Code 2	Description
Diagnostic Category 3	**Diagnosis Code 3**	**Description**

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AGENCY: _____ **RIN:** _____

Diagnostic Category 4	Diagnosis Code 4	Description
Diagnostic Category 5	**Diagnosis Code 5**	**Description**

PRIMARY MEDICAL DIAGNOSIS (DSM-5) *Required Field

*Diagnostic Category 1	Diagnosis Code 1	Description
Diagnostic Category 2	**Diagnosis Code 2**	**Description**
Diagnostic Category 3	**Diagnosis Code 3**	**Description**

SOCIAL ELEMENTS IMPACTING DIAGNOSIS (DSM-5) *Check all that apply (Required)

☐ None	☐ Problems with access to health care services	☐ Housing Problems (Not Homelessness)	☐ Problems related to the social environment
☐ Educational problems	☐ Problems related to interaction w/legal system/crime	☐ Occupational problems	☐ Homelessness
☐ Financial Problems	☐ Problems with primary support group	☐ Medical disabilities that impact diagnosis or must be accommodated for in treatment	☐ Unknown
☐ Other psychosocial and environmental problems			

FUNCTIONAL ASSESSMENT (DSM-5) Required

Assessment Measure	Assessment Score	Secondary Assessment Measure	Assessment Score
☐ GAF		☐ Not Applicable	

III. LOCUS SCORE AT TIME OF DISCONTINUED SERVICE
MUST Complete all domains from the LOCUS tool)

DOMAIN SCORES:

Risk of Harm: _____ **Recovery Environment-Environmental Stressors:** _____

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

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

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AGENCY: _____ **RIN:** _____

LOCUS SCORE RECOMMENDED AT TIME OF DISCONTINUATION: **Composite Score:** _____

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

ASSESSOR RECOMMENDED LEVEL OF CARE *(In accordance with services crosswalk)*

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

Reason for Deviation *(If Applicable)*
Explain:

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

TRANSITION START DATE: _____ **TRANSITION END DATE:** _____

PLEASE NOTE THAT INCOMPLETE FORMS WILL BE RETURNED