

North Sound PACT Referral

Overview

Lifeline Connections' North Sound Program of Assertive Community Treatment (PACT) is a community-based program consisting of a transdisciplinary team of clinicians who provide intensive, wraparound services to adults with severe and persistent mental health disorders. Services include, but are not limited to, care coordination, crisis intervention, psychotherapy, psychoeducation, wellness management, psychiatric medication management, co-occurring disorders services, vocational services, psychosocial rehabilitation, and peer support.

Eligibility Criteria

- **Resides in Whatcom County**
- **A primary diagnosis of schizophrenia, schizoaffective disorder, or bipolar disorder with psychotic features***
- **Significant functional impairments** (e.g., difficulty performing ADLs, maintaining employment, or maintaining a safe living environment) – *see page 4 for more information*
- **Continuous high service needs** (e.g., high utilization of crisis/emergency services, significant criminal justice involvement, difficulty meeting basic needs, inability to live independently without intensive services, difficulty utilizing or benefitting from traditional office-based services) – *see page 4 for more information*

**PACT does not work well for clients whose primary diagnosis is a personality disorder, substance use disorder, traumatic brain injury, or developmental disability.*

Please complete and submit this referral packet, as well as the following documentation, if available:**

- Mental Health Assessment
- Psychiatric Evaluation
- Medication list (include MAR if available)
- Recent chart notes
- Release of information for Lifeline Connections (must be included)

***If the referral comes from an agency that provides mental health services, the referral will not be reviewed until all necessary information is provided.*

Fax completed referral to 360-318-7333

For any questions about the referral form or to consult about potential referrals, please contact:

Hannah Sloan, Clinical Program Director – hsloan@lifelineconnections.org or 360-450-3780

Kyra Hasley, PACT Team Lead – khasley@lifelineconnections.org or 360-949-6759

Referral Information

Referral Date:	Referring Individual:
Have PACT Services been discussed with the client? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how open are they to the program? If no, why? _____	Agency/Job Title:
	Phone number/Fax:
	Email:
Client Name:	Client DOB (must be over 18):
Client Address:	Client Phone Number:
What insurance does the client have? <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Spenddown (Amount: \$_____) <input type="checkbox"/> No Insurance <input type="checkbox"/> Private Insurance Additional information (e.g., MCO, Provider One ID): _____	
Guardian (if applicable, provide copy of court order): Payee: _____ Mental Health or Medical Advance Directive (Provide copy): <input type="checkbox"/> Yes <input type="checkbox"/> No	

Clinical Information

Does the individual being referred have a DSM-V diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No Please list known diagnoses, including any substance use disorders:
Diagnosis 1:
Diagnosis 2:
Diagnosis 3:

Does the client have a personality disorder, either documented or suspected? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain: _____
Does the client have a developmental disability? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain: _____
Does the client have a PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of PCP: _____
Medical issues (current/past):

Behavioral Health Service History

Please include current and past behavioral health services client has received, including mental health and substance use treatment, with details as available:

Program/Agency	Reason for Treatment (include level of engagement)	Dates
_____	_____	_____
_____	_____	_____
_____	_____	_____

Hospitalization History

Please include all known hospitalizations, with details as available:

Hospital/Facility	Reason for Hospitalization (include if voluntary/involuntary)	Dates
_____	_____	_____
_____	_____	_____
_____	_____	_____

Legal History

Please include all known incarcerations, arrests, or other law enforcement contacts, with details as available:

Location (county, facility)	Charges/Reason for Arrest	Dates

Clinical Eligibility

As previously mentioned, individuals must meet several criteria as PACT provides a certain level of care required by fidelity standards. The following information, in addition to the diagnostic information collected above, helps us determine a recommended level of care.

Functional Impairments

*The individual experiences significant functional impairments as demonstrated by **at least one** of the following (please check all that apply):*

- Significant difficulty consistently performing the range of practical daily living tasks required for basic adult functioning in the community (e.g., caring for personal business affairs; obtaining medical, legal, and housing services; recognizing and avoiding common dangers or hazards to self and possessions; meeting nutritional needs; maintaining personal hygiene)
- Persistent or recurrent difficulty performing daily living tasks except with significant support or assistance from others (e.g., friends, relatives, caregivers)
- Significant difficulty maintaining consistent employment at a self-sustaining level.
- Significant difficulty consistently carrying out the homemaker role (e.g., household meal preparation; washing clothes; budgeting; childcare tasks/responsibilities)
- Significant difficulty maintaining a safe living situation (e.g., repeated evictions or loss of housing; forgetting to turn stove burners off; consistent unsanitary conditions due to uncollected garbage)

Service Needs

*The individual has continuous high service needs as demonstrated by **at least one** of the following (please check all that apply):*

- High use of acute psychiatric hospitals (e.g., 2 or more admissions per year) or psychiatric emergency services
- Intractable (i.e., persistent or very recurrent) and severe major symptoms (e.g., affective, psychotic, suicidal)
- Co-occurring substance use disorder of significant duration (e.g., greater than 6 months)
- High risk or recent history of criminal justice involvement (e.g., arrests, incarceration, probation)
- Significant difficulty meeting basic survival needs, residing in substandard housing, homeless, or at imminent risk of becoming homeless
- Residing in an inpatient or supervised community residence, but clinically assessed to be able to live in a more independent living situation if intensive services are provided or requiring a residential or institutional placement if more intensive services are not available.
- Difficulty effectively utilizing or benefitting from traditional office-based outpatient services or other less intensive community-based programs (e.g., consumer fails to progress, drops out of services)

PACT provides the following services (please check all services requested by the client and/or referring individual):	Client Requests	Referral Source Requests
Assistance with Medical/Dental Care	<input type="checkbox"/>	<input type="checkbox"/>
Medication Management	<input type="checkbox"/>	<input type="checkbox"/>
Assistance with Activities of Daily Living (ADLs) (e.g., shopping, hygiene, cooking)	<input type="checkbox"/>	<input type="checkbox"/>
Assistance with Money Management	<input type="checkbox"/>	<input type="checkbox"/>
Assistance with Employment/Education	<input type="checkbox"/>	<input type="checkbox"/>
Assistance with Mental Health Therapy/Counseling	<input type="checkbox"/>	<input type="checkbox"/>
Assistance with Cultural Differences	<input type="checkbox"/>	<input type="checkbox"/>
Assistance with Social Skills	<input type="checkbox"/>	<input type="checkbox"/>
Assistance with Transportation to medical appointments and/or grocery shopping	<input type="checkbox"/>	<input type="checkbox"/>
Assistance with reducing/stopping Drugs/Alcohol/Tobacco use	<input type="checkbox"/>	<input type="checkbox"/>
Assistance with Leisure Activities (Hobbies/Skills)	<input type="checkbox"/>	<input type="checkbox"/>
Assistance Connecting/Reuniting with Family/Supports	<input type="checkbox"/>	<input type="checkbox"/>

***Please feel free to include additional information on a separate sheet to more clearly depict the individual’s needs and request for services.**

STAFF USE ONLY

Does Client meet the minimum qualification of the Program? If not, why?

Can PACT provide services needed to meet patient needs?

If not, what referrals were provided: _____

Is the individual willing to meet with a PACT case manager or MHP for an intake assessment? Yes No

Date of Assessment: _____

Client’s Name: [Click here to enter text.](#)