FACT REFERRAL PROCESS

Step 1:
Complete the attached referral forms. These forms include basic information on hospitalizations, arrests, detox, admissions, and brief explanation of why FACT services are being requested. Please ensure form is complete.

Step 2:
Fax the completed referral forms to the FACT Program. The fax number is (321)504-3462. Identify the document as a FACT Referral on the fax cover sheet. DIRECT (321)504-3888

Step 3:
Once the completed referral forms are received, FACT will review the referral with SAMH. A face-to-face meeting may occur with the FACT candidate if necessary to complete the assessment.

Step 4:
The FACT /SAMH staff will determine if the person is appropriate for FACT services.

FLORIDA ASSERTIVE COMMUNITY TREATMENT (FACT) PROGRAM
MENTAL HEALTH RESOURCE CENTER

Location: 500 Barton Boulevard, Suite # 7
Rockledge, Florida 32955

Phone: (321) 504-3888 Direct #
(321) 504-3462 Fax #

Contact Person: **Brooke Altonaga, LCSW, FACT Program Manager**

E-mail: baltonaga@mhrcflorida.com

Program Hours: 7:00 am to 7:00 pm, Monday thru Friday
8:00 am to 4:00 pm, Weekends & Holidays
24 Hour on-call coverage

Program Description: The FACT program serves adults with severe and persistent mental illness, who may also have a co-occurring substance abuse disorder. The program's multidisciplinary staff obtains or directly provides all mental health services to FACT participants, primarily in their homes or the community, including: Psychiatric Care, Medical Referral and Follow-Up, Individual Supportive Therapy, Crisis Assessment and Intervention, Substance Abuse Services, Work-Related Vocational Services, Support in Activities of Daily Living, Social, Interpersonal Relationship and Leisure Time Training, Case Management Services, and Supportive Services. In addition, the program assists participants in arranging for affordable housing that may include assistance with security deposits, utilities and rent.

Persons Served/Program Eligibility: Adults who are reported to have severe and persistent mental illness and meet the DSM-IV criteria in one of the following diagnostic categories: Schizophrenia and Other Psychotic Disorders (295 series) Mood Disorders (296 series), Anxiety Disorders (300 series) and Personality Disorders (301 series). Eligible individuals demonstrate a high-level service usage (mental health, substance abuse treatment, and/or judicial system, with priority given to persons with three (3) or more admissions to any combination of these services). In addition, individuals eligible for admission: (1) Have not been adequately served in the traditional delivery system:(2) Are at high risk of repeated psychiatric hospital admissions, prolonged inpatient psychiatric or State hospitalizations, or repeated crisis stabilization use because of their severe psychiatric systems: (3) Have significant interpersonal impairments and a lack of available community resources: (4) May have co-occurring substance abuse disorders: (5) May be homeless: (6) May be involved with the local judiciary due to various misdemeanor violations. A person will not be excluded from eligibility based on mild mental retardation, physical disabilities, or HIV/AIDS. Call the FACT program office for more information.

Referral Process: Anyone may call the FACT program office to obtain a FACT Program Referral and Brief Assessment form, which should be completed and returned to the FACT program office.

MHRC FACT Referral Form (Osceola and Brevard) March 1, 2015

Date: Referral/Transfer Type: Civil Forensic (__ separate page attached)

*******Consumer Demographic Information*******

Name: _____ Male____ Female____

Address: _____
Street City State County

SSN: _____ Phone: _____(home) _____(other)

Age/DOB: ____ ____/____/____ Contact Person: _____
Name/Relationship/Phone

Living Situation: Home/Independent____ Living with Family/Friends____ ALF____ Homeless ____
Local Hospital Diversion____ RT____ AFP____ Jail/Prison____ State Hospital___
Other:

*******Treatment/Service History – Provider*******

Current: Case Mgmt _____ DBT/Special Program _____
Partial Hosp. _____ Med Clinic_____
Hospitalizations (dates/type of hospitalization): _____

Reason for Referral: _____

Referred by/Agency/Phone/E-mail:

*******Multiaxial Diagnoses*******

Axis I: _____ _____

Axis II: _____ _____

Axis III: _____

Axis IV: _____

Axis V: _____/Current _____/Past Year

*******Current Medications*******
(include Name/Dosage/Route/When Taken/Reason)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

*******Clinical Data*******

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

*****Admission Criteria*****

Name: _____

Funding Source(s): _____

_____

ONE of the following diagnosis categories:
__ Schizophrenia, other Psychotic Disorders(295 series)
__ Mood Disorders (296 series)
__ Anxiety Disorders (300 series)
__ Personality Disorders (301 series)

Additionally, must meet ONE of the following SIX criteria:
__Demonstrate a high risk for hospital admission or re- admission;
__Have prolonged inpatient days(90+ within one calendar year);
__Have repeated, 3+ episodes per calendar year, local criminal justice involvement;
__Have been referred for aftercare services by one of the states correctional institutions;
__Referred from an inpatient detox unit and documented history of co-occurring disorders;
__Have repeated, 3+ admissions within one calendar year, to a crisis stabilization unit and;

Meet at least THREE of SIX of following characteristics:
___inability to consistently perform ADL skills or failure to perform them without significant support/assistance;
___inability to be consistently employed (self-sustaining level) or inability to consistently carry out the homemaker role
___inability to maintain safe living situation.
___coexisting substance use disorder (6+ months)
___high or recent criminal justice history
___coexisting mild mental retardation
___destructive behavior to self and others

Person Served agrees with referral? Yes / No (circle one) N/A

Guardian/Legal Representative Agrees? Y / N (circle one)

*****Supportive Documentation attached*****

Clinical Documentation of D/O Medication Documentation of D/O Psychosocial Assessment
Psychiatric Evaluation Medical History Other _____

_____

_____

_____

*****Benefits*****

___Medicaid ___Social Security ___Private Insurance ___Other: Specify _____

_____

_____

_____