

Client Demographic Information		
Client Name (Last, First)	Date of Birth	Today's Date
Address	City, State	Zip Code
Phone Number	MRN # (if applicable):	
How does the client meet ACT criteria? (Please check all that apply.)		
1. Primary Mental Health Diagnosis of:	<input type="checkbox"/> Schizophrenia	
	<input type="checkbox"/> Schizoaffective Disorder	
	<input type="checkbox"/> Bipolar Disorder (Severe and Recurrent)	
	<input type="checkbox"/> Major Depressive Disorder (Severe and recurrent)	
	Other:	
2. Significant Functional Impairment: (please explain)	Daily tasks of adult functioning:	
	Difficulty maintaining employment:	
	Difficulty maintaining safe living situation:	
3. High cost/treatment failure in traditional services:	<input type="checkbox"/> Two or more in-patient admission in past 24 months	
	<input type="checkbox"/> Greater than 4 weeks of hospitalization in the past 12 months	
	<input type="checkbox"/> Greater than 3 months of residential care in the past 12 months	
	<input type="checkbox"/> Decompensation or high risk of decompensation with traditional treatment due to treatment noncompliance, or severe life stress	
4. Residence within one of these 8 counties:	<input type="checkbox"/> Clay <input type="checkbox"/> Dickinson <input type="checkbox"/> Emmet <input type="checkbox"/> Lyon <input type="checkbox"/> O'Brien <input type="checkbox"/> Osceola <input type="checkbox"/> Palo Alto <input type="checkbox"/> Sioux	
5. Iowa Medicaid	Amerigroup #: Iowa Total Care #:	
Previous/Current Services		
Psychiatrist:	Primary Care Provider:	
Physical Health Conditions or Diagnosis:		
Current Medications	Dosage	
Services Utilized in past 2 years (therapists, in-home services, residential care):		
Psychiatric Hospitalizations in past 2 years: ___ Days ___ Weeks	Incarcerations in past 2 years: ___ Days ___ Weeks	
Referral Source:	Phone #:	Email Address:
Please return completed forms to ACT@seasonscenter.org.		