

**Please choose the ACT service location to send referral to in order for it to be processed at the correct location:**

- ☐ 235 Civic Center Blvd. Houma, LA 70360
 ☐ 312 E. Bayou Rd., Thibodaux, LA 70301  
☐ 2407 Baronne St., New Orleans, LA 70113
 ☐ 1505 N. Florida St., Covington, LA 70433  
☐ 9420 Lindale Avenue, Suite A, Baton Rouge, LA 70815

|  |  |  |           |
|--|--|--|-----------|
| Participant Name:  |  | DOB:   | Date:     |
| Primary Phone Number:  |  | Alternative Number: ; <input type="checkbox"/> N/A |           |
| Home Address:  |  | City/State:  | Zip Code: |
| Has Medicaid? <input type="checkbox"/> YES <input type="checkbox"/> NO | Verified: <input type="checkbox"/> YES <input type="checkbox"/> NO | Medicaid Number:                                   |           |
| Bayou Health Plan:   |  | Other Insurance/Medicare:                          |           |
| <b>Referral Source</b>   |  |  |           |
| Referral Source Name:  |  | Referral Completed by:                             |           |
| Contact Number:  |  | Email:   |           |
| <b>Referral Information</b>  |  |  |           |
| Reason for Referral:   |  |  |           |
| Psychiatric Diagnoses:   |  |  |           |
| Current Medications:   |  |  |           |
| History of Psychiatric Hospitalization:                                |  |  |           |
| Any current legal charges:   |  |  |           |
| Additional Comments:   |  |  |           |

Referral packet can be emailed to [actreferrals@startcorp.org](mailto:actreferrals@startcorp.org) or faxed to (225) 377-4197

**Referent, please fill out the following:**

|  |       |
|--|-------|
| Participant Name:  | Date: |
| <b>DIAGNOSIS</b>   |       |
| <b><i>The individual must have one of the following diagnoses:</i></b>   |       |
| <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Schizoaffective Disorder <input type="checkbox"/> Bipolar Disorder <input type="checkbox"/> Major Depressive Disorder<br><input type="checkbox"/> Other psychotic disorder: _____  |       |
| <b><i>These diagnoses are also accompanied by:</i></b>   |       |
| <input type="checkbox"/> Substance Use Disorder <input type="checkbox"/> Developmental Disability  |       |
| <b>SERVICE NEEDS</b>   |       |
| <b><i>The individual must have one or more of the following:</i></b>   |       |
| <input type="checkbox"/> Two or more acute psychiatric hospitalizations and/or four or more Emergency Room visits in the last 6 months<br><input type="checkbox"/> Persistent and severe symptoms of a psychiatric disability that interferes with the ability to function in daily life   |       |
| <b><i>The individual must have one or more of the following:</i></b>   |       |
| <input type="checkbox"/> Inability to participate or remain engaged or respond to traditional community-based services<br><input type="checkbox"/> Inability to meet basic survival needs or residing in substandard housing, homeless, or is at imminent risk of becoming homeless  |       |
| <b><i>The individual must have three of the following:</i></b>   |       |
| <input type="checkbox"/> Evidence of a co-existing mental illness and substance abuse / dependence<br><input type="checkbox"/> Significant suicidal ideation with a plan and ability to carry out within the last two years<br><input type="checkbox"/> Suicide attempt in the last two years<br><input type="checkbox"/> History of violence due to untreated mental illness / substance abuse within the last two years<br><input type="checkbox"/> Lack of support systems<br><input type="checkbox"/> History of inadequate follow-through with community-based services<br><input type="checkbox"/> Threats of harm to others in the past two years<br><input type="checkbox"/> History of significant psychotic symptomatology such as command hallucinations to harm others |       |
| <b>Additional Information:</b>   |       |
|  |       |

Referral Source (Print Name)

Referral Source (Signature)

Date

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