COMMUNITY INTEGRATED Health Services

Community Integrated Health Services

Flexible Assertive Community Treatment (FACT) Referral Form

The FACT program provides services for individuals with chronic and intensive mental health needs who have a history of multiple visits to an emergency department, inpatient psychiatric hospitalizations and/or contacts with law enforcement related to their behavioral health challenges.

This is a voluntary program for individuals who are eligible for Medicaid, who have a primary behavioral health diagnosis, and who meet program eligibility standards.

Instructions:

- **Submit this referral form and any attachments via Fax: (844) 554-3370** or **(360) 748-4480, in person,** or **by mail** (see next page for mailing addresses.)
- Please complete this referral form and attach any additional information if available.
- The referring entity must obtain a signed authorization for Release of Information (ROI) and attach it to this referral form.
- CIHS will confirm receipt of the referral, and will contact the individual being referred within seven business days of receipt of request.

Individual Being Referred

Please select the county where you anticipate services will be provided (individual's county of residence):

☐ **Cowlitz** ▣ **Lewis** ☐ **Grays Harbor**

Date of Referral: _____

First Name: _____ **DOB:** _____

Last Name: _____ **Phone #:** _____

Street Address: _____ Email: _____

City: _____ Provider One #: _____

State: _____ Zip: _____

Referring Entity

Agency: _____ Phone #: _____

Contact: _____ Fax #: _____

Title: _____ Email: _____

Reason for Referral

What are this individual's current bio-psycho-social needs? How would they benefit from the intensive outpatient behavioral health services provided by FACT?

_____

_____

_____

_____

_____

_____

Diagnostic Information (Behavioral Health)	
ICD-10 CODE	**DIAGNOSIS**

Currently Incarcerated: ☐ No ☐ Yes; where: _____

Reason for Incarceration: _____

Currently in Psychiatric Hospital: ☐ No ☐ Yes; where: _____

Reason for Hospitalization: _____

_____

Please Provide:
- ☐ Nurse and Doctor Notes for duration of stay
- ☐ Social Work/Mental Health Professional Notes for duration of stay
- ☐ Labs/UDS
- ☐ Current Medication List
- ☐ Discharge Summary

Is individual on a Less Restrictive Alternative (LRA) or Conditional Release (CR): ☐ **No** ☐ **Yes**

If yes, who is monitoring: _____

Document required (check and ensure attached):

☐ Signed copy of **release of information** for CIHS to exchange and share information with referring agency

Requested Documentation (please check all that you are able to provide at time of referral):

- ☐ Copy of Assessment (Mental Health & Substance Use if ROI allows)
- ☐ Current Treatment Plan
- ☐ Crisis Plan
- ☐ List of Hospitalizations and dates of services, if known
- ☐ Copy of current psychiatric medication list
- ☐ Summary of current medical conditions, physical health medications and treatment for medical needs
- ☐ Other: _____

Community Integrated Health Services (CIHS)
Cowlitz County Mailing Address: P.O. Box 1054, Longview, WA 98632
Grays Harbor County Mailing Address: P.O. Box 178, Hoquiam, WA 98550
Lewis County Mailing Address: P.O. Box 579, Centralia, WA 98531
Phone: (360) 261-6930 or (855) 303-4834 | **Fax**: (360) 748-4480 or (844) 554-3370
Website: www.cihealthservices.com

For Office Use Only:

Date Received: **Received Via:** ☐ Fax ☐ In Person ☐ Mail ☐ Other: