Assertive Community Treatment (ACT) Minimum Encounter Exception Form

Date:	Member name:

Member date of birth:	Medicaid/Health plan #:
Requesting provider/agency:	NPI#:
	TIN#:

Level of functional impairment: ☐ No impairment ☐ Mild ☐ Moderate ☐ Severe
Progress towards goals: ☐ Making progress towards goals ☐ Lack of adherence and/or progress

Date of face-to-face (FTF) encounter service	Place of service/mode of delivery (e.g., office, community, phone, video, behavioral health integrated program, substance use disorder program, nursing home)	Duration of encounter

How many contacts were made on the client’s behalf with someone other than the client?

How many unsuccessful attempted contacts were made with the client?

Collateral sources contacted (name of people, facility, etc.):

Brief narrative description of clinically appropriate reasons for less than six FTF contacts:

In the two months before this month, how many FTF contacts were made?

Month:	#FTF contacts:	Month:	#FTF contacts:

Explain plan to increase frequency of contact or to graduate/transition:

☐ I certify that the information shown is true, correct, and accurate.

☐ I have attached clinical documentation to support this exception request.

Name and credentials of person completing form:

Signature of person completing form:

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