

Intensive Home-Based Services (IHBS) Referral & Authorization

NAME / MRN _____

Facility Name: _____ ID: _____ Program Name: _____ ID: _____
 Provider: _____ ID: _____ Service Date: _____
 Direct Service Time (Min): _____ Documentation Time (Min): _____ Travel Time (Min): _____
 Number in Group: _____ CPT/HCPC Code: _____ Quantity: _____

LIST OF DOCUMENTS TO INCLUDE IN REFERRAL PACKET.

For each of the following documents, please indicate whether it is included or if it does not apply to this referral.
NOTE: Organizing the referral packet so items are in the order listed below would be greatly appreciated.

	<u>Included</u>	<u>N/A</u>
1. Completed IHBS Referral Form (MHC-305)	<input type="checkbox"/>	<input type="checkbox"/>
2. Current ICC Eligibility Evaluation Form (MHC-300)	<input type="checkbox"/>	<input type="checkbox"/>
3. Current ICC 90-Day Eligibility Review/Progress Notes	<input type="checkbox"/>	<input type="checkbox"/>
4. Most recent assessment (MHC-033)	<input type="checkbox"/>	<input type="checkbox"/>
5. Current Problem List (MHC-018)	<input type="checkbox"/>	<input type="checkbox"/>
6. Current Pediatric Symptom Checklist (PSC-35)	<input type="checkbox"/>	<input type="checkbox"/>
7. Current CANS (MHC-118)	<input type="checkbox"/>	<input type="checkbox"/>

Is this child/youth involved with CFS? Yes No **Presumptively transferred?** Yes No

If client is a Contra Costa dependent, please include the following two items: **Included** **N/A**

- | | | |
|---|--------------------------|--------------------------|
| 1. Signed DC 5A: Authorization for Medical Treatment | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Signed DC 5B: Authorization to Release Information | <input type="checkbox"/> | <input type="checkbox"/> |

Referral Packet Completed by: _____ Date: _____
 (Signature Service Provider/Licensure/Designation)

 (Printed Name Service Provider)

Approval by County Program Manager: _____ Date: _____
 (Signature Program Manager/Licensure/Designation)

 (Printed Name Program Manager)

Referral Made to: _____ Date: _____
 (Name of IHBS Program)

INTENSIVE HOME-BASED SERVICES REFERRAL INFORMATION

Client's Name: _____ DOB: _____

MRN: _____ Ethnicity: _____ Preferred Pronouns: _____

Gender: Male Female Transgender Non-binaryClient Primary Language: English Spanish Other _____Family Primary Language: English Spanish Other _____

Client's Current Address: _____

Current School: _____ Current Grade: _____ Special Ed.

Current Caregiver: _____ Relationship: _____ Phone#: _____

Legally Responsible Party: _____ Relationship: _____ Phone#: _____

Does the above-mentioned child/youth have an open Child Welfare Case? Yes No**ICC Eligibility is established if ALL of the following criteria (1-3) are met:**

1. Does the above-mentioned child/youth have full-scope Medi-Cal? Yes No
2. Does the above-mentioned child/youth meet access criteria for ICC services? Yes No
3. Is the child currently receiving or being considered for any of the following service(s): Yes No

Check all that apply:

- Wraparound
- Specialized Care Rate due to Behavioral Health Needs
- Receiving intensive SMHS, including, but not limited to, Therapeutic Behavioral Services, Crisis Stabilization (PES), or Crisis Intervention (PES/MRT)
- Group Home (RCL 10 or higher) or Short Term Residential Therapeutic Programs (STRTP)
- Experienced two or more placements due to behavioral health needs in the last 24 months
- Psychiatric Hospital/24-Hour Mental Health Facility, or discharged in the last 90 days
- Two or more mental health hospitalizations in the last 12 months
- Two or more emergency room visits in the last 6 months due to primary mental health condition including, but not limited to, involuntary treatment under California Welfare and Institution Code section 5585.50
- Treated with two or more antipsychotic medications at the same time over a 3-month period
- Treated with one psychotropic medication, for child/youth 5 years and younger
- Treated with two psychotropic medications, for child/youth age 6-11 years
- Treated with three psychotropic medications, for child/youth age 12-17 years
- Diagnosed with more than one mental health diagnosis, for child/youth 5 years and younger
- Diagnosed with more than two mental health diagnoses, for child/youth age 6-11 years
- Diagnosed with more than three mental health diagnoses, for child/youth age 12-17 years
- Has been detained pursuant to W&I sections 601 and 602 primarily due to mental health needs
- Has received SMHS within the last year and has been reported homeless in the last 6 months
- Other:

JUSTIFICATION FOR IHBS

1. Describe in detail the behaviors that (1) interfere with child/youth's independent living objectives, such as seeking and maintaining housing and/or seeking and maintaining a job, (2) interfere with child/youth's success in achieving educational objectives in an academic program in the community.
2. Describe the child/youth's strengths:
3. Describe the behaviors that interfere with the achievement of a stable and permanent family life:
(How can IHBS possibly help improve child/youth's functioning, life skills, etc.)
4. Describe the transition plan:
5. If the child/youth is currently being served by existing EPSDT (ICC, therapy, WRAPAROUND, TBS) or other specialty mental health services, how will the addition of IHBS benefit the client/youth/family?
(Please list all MH services the child/youth is currently receiving.)

Child/family would benefit from referral for:

- IHBS Family Partner (*support primarily for the caregiver*)
- IHBS Community Liaison (*support primarily for the child/adolescent*)

List name, phone number, and email of active Child and Family Team members as of date of referral. Check "N/A" if no member is serving in that capacity.

N/A Capacity

- Intensive Care Coordinator (ICC): _____
- Social Worker: _____
- Mother(s): _____
- Father(s): _____
- Foster Parent(s): _____
- Sibling(s): _____
- NRFM or Guardian: _____
- TBS Provider: _____
- Therapist: _____
- Family Partner: _____
- Wrap Facilitator: _____
- Group Home Contact: _____
- FFA Contact: _____
- Family Court Lawyer: _____
- Other: _____

Additional Notes: