



Intensive Care Coordination (ICC) Eligibility Evaluation

NAME / MRN _____

Date: _____

Minute(s): _____

Service Code: 314 ICC Evaluation
 540 Non-Bill

Provider Name: _____

Provider #: _____

Program Name: _____

FAC/PROG: _____

Place of Service (check one)

<input type="checkbox"/> Office	<input type="checkbox"/> Inpatient Psychiatric	<input type="checkbox"/> Residential Txt Center (Child)	<input type="checkbox"/> Telehealth – Pt Home
<input type="checkbox"/> Field	<input type="checkbox"/> Inpatient Health	<input type="checkbox"/> Residential Txt Center (Adult)	<input type="checkbox"/> Telehealth – Other than Pt Home
<input type="checkbox"/> Phone	<input type="checkbox"/> Emergency Room	<input type="checkbox"/> Hospice	<input type="checkbox"/> Age Specialty Center
<input type="checkbox"/> Home	<input type="checkbox"/> Jail	<input type="checkbox"/> Skilled Nursing Facility	<input type="checkbox"/> Faith Based Location
<input type="checkbox"/> School	<input type="checkbox"/> Emergency Shelter	<input type="checkbox"/> Mobile Service	<input type="checkbox"/> Nontraditional Location
<input type="checkbox"/> Satellite	<input type="checkbox"/> Primary Care Health Clinic	<input type="checkbox"/> Job Site	<input type="checkbox"/> Other Location

Initial Determination
 General Re-evaluation
 Annual
 90-Day Re-evaluation
 (as needed) (For ICC use only)

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 Medical Necessity criteria? Yes No
3. Is the child currently receiving or being considered for any of the following service(s)? *If so, check all that apply.* Yes No

- Wraparound
- Specialized Care Rate due to Behavioral Health Needs (Extra aid to some families w/foster youth)
- Receiving intensive SMHS, including but not limited to Therapeutic Behavioral Services or Crisis Stabilization (PES), Crisis Intervention (PES/MRT)
- Group Home (RCL 10 or higher) or Short Term Residential Therapeutic Program (STRTP)
- Experienced two (2) or more placements due to behavioral health needs in the past 24 months
- Psychiatric Hospital/24 Hour Mental Health Facility or discharged within past 90 days
- Two or more mental health hospitalizations in last twelve (12) months
- Two or more emergency room visits in the last six (6) months due to primary mental health condition 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 three (3)-month period
- Treated with one psychotropic medication, for child/youth age 5 years or 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 age 5 years or 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
- Have been detained pursuant to W&I sections 601 and 602 primarily due to mental health needs
- Have received SMHS within the last year and have been reported homeless within the prior six (6) months
- Other:

Additional Comments:**DETERMINATION**

- Client meets ICC eligibility criteria.**
If ICC-eligible, what is the child/youth's current living situation?
- | | |
|--|---------------------------------------|
| <input type="checkbox"/> Home with immediate family | <input type="checkbox"/> Foster home |
| <input type="checkbox"/> Home with extended family (relatives) | <input type="checkbox"/> Group home |
| <input type="checkbox"/> Home with non-related persons | <input type="checkbox"/> Other: _____ |

For Initial Evaluation Services:

- Client meets ICC eligibility criteria and has AGREED to ICC services.**
 (Submit ICC Referral form to ICCReferrals@cchealth.org for assignment)
- Client meets ICC eligibility criteria, but child/youth/family has DECLINED ICC services:**

Name of Person Declining ICC Services / Relationship to Client

Date Declined

- Client meets ICC eligibility criteria, but SERVICES ARE CLOSING due to:**
- | | |
|---|---|
| <input type="checkbox"/> Mutual team agreement | <input type="checkbox"/> Incarceration |
| <input type="checkbox"/> Presumptive transfer/Moved out of area | <input type="checkbox"/> Location unknown |
| <input type="checkbox"/> Other: _____ | |
- Client does NOT meet ICC eligibility. Please indicate course of action:**
- Referral to MH Liaison (*CFS-involved beneficiaries only*):
- _____
Liaison Name/Region
- Referral to other: _____
- No referral needed

Assessor's Signature/License/Designation

Printed Name

Date

For Continuing ICC Services: (For ICC use only)

ICC services continuing:

Determined by: _____
ICC's Signature/License/Designation _____
Date

Date eligibility to be re-evaluated by (*must be within 90 days*): _____
Date

(This section to be completed by the County ICC's supervisor or their designee at initial ICC assignment)

DISPOSITION

ICC assigned: _____
Program/Agency

ICC Supervisor's Signature/License/Designation *Printed Name* _____
Date

Date eligibility to be re-evaluated by (*must be within 90 days*): _____
Date