CONTRA COSTA
BEHAVIORAL HEALTH
A Division of Contra Costa Health Services

Intensive Home-Based Services (IHBS) Referral & Authorization

NAME / MRN _____

Date: _____ Min(s): _____ Service Code: ☑ **315** Plan Development

Provider Name: _____ Provider #: _____

Program Name: _____ FAC/PROG: _____

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.**

		Included	N/A
1.	Completed IHBS Referral Form (MHC-305)	☐	☐
2.	ICC Eligibility Evaluation Form (Initial) (MHC-300)	☐	☐
3.	ICC 90-Day Eligibility Review/Progress Notes (Current Review)	☐	☐
4.	Initial Assessment (MHC-033)	☐	☐
5.	Annual Assessment (MHC-065) - if Initial is older than 6 months	☐	☐
6.	Current Partnership Plan (MHC-021)	☐	☐
7.	Pediatric Symptom Checklist (PSC-35)	☐	☐
8.	Current CANS	☐	☐
9.	Current MH Face Sheet (SCR 4524)	☐	☐
10.	Coordinated Services Form	☐	☐

Is this child/youth involved with CFS? Yes ☐ No ☐

If so, please include the following two items:	Included	N/A
1. Signed DC 5A: Authorization for Medical Treatment	☐	☐
2. Signed DC 5B: Authorization to Release Information	☐	☐

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)

NAME/MRN

INTENSIVE HOME-BASED SERVICES REFERRAL INFORMATION

Client's Name: _____ MRN: _____

Gender: ☐ Male ☐ Female ☐ Transgender ☐ Non-binary DOB: _____ Ethnicity: _____

Client 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 Medical Necessity criteria? ☐ 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:

NAME/MRN

JUSTIFICATION FOR IHBS

1. **Describe in detail the behavior(s) or mental health conditions that interfere with the child/youth's functioning in the home and/or the community:** ***(i.e., describe 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.)***

NAME/MRN

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):	_____
☐	Siblings:	_____
☐	NRFM or Guardian:	_____
☐	TBS Provider:	_____
☐	Therapist:	_____
☐	Family Partner:	_____
☐	Wrap Facilitator:	_____
☐	Group Home Contact:	_____
☐	FFA Contact:	_____
☐	Family Court Lawyer:	_____
☐	Other:	_____

Additional Notes: