CONTRA COSTA
BEHAVIORAL HEALTH
A Division of Contra Costa Health Services

Intensive Care Coordination (ICC) Referral Request

NAME / MRN

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

Primary Clinician: _____ Provider #:_____

Program Name: _____ FAC/PROG: _____

Intensive Care Coordination (ICC) is a medically necessary service and is similar to activities provided as Targeted Case Management (TCM) but requires greater frequency and more participation. ICC services must be delivered using a Child and Family Team (CFT) to develop and guide the planning and service delivery process. Though there may be several participants participating in CFTs, there must be an identified mental health ICC coordinator to ensure participation by the child /youth, family or caregiver, and significant others so the assessment, including on-going re-assessment and treatment planning, addresses the child/youth's needs and strengths in the context of the values.

REFERRAL PACKET MUST INCLUDE:

- ☐ ICC Cover Sheet/ICC Referral Request (form MHC-305)
- ☐ MH Face Sheet (SCR 4524)
- ☐ Medi-Cal Verification Report

From the Chart:

- ☐ Copy of the client's most current Assessment Form (form MHC-033 or MHC-065). (If the most current assessment is an Annual Assessment, please include the Initial Assessment as well)
- ☐ Current Child and Adolescent Needs and Strengths (CANS) (form MHC-118)
- ☐ Pediatric Symptom Checklist (PSC-35) (form MHC-120)
- ☐ Copy of the client's Partnership Plan for Wellness (form MHC-021) – (Include the client's referral for ICC services within the body of the partnership plan).
- ☐ Copy of signed Consent for Coordinated Services (form MHC-111)
- ☐ Service Authorization form (form MHC-036)
- ☐ Copy of ICC Eligibility Evaluation (form MHC-300)

Is client involved with CFS? Yes ☐ No ☐ Presumptive Transfer? Yes ☐ No ☐ _____
County or Jurisdiction

If so, please submit the following:

- ☐ Signed DC 5A: Authorization for Medical Treatment (for Contra Costa CFS beneficiaries only)
- ☐ Signed DC 5B: Authorization to Release Information (for Contra Costa CFS beneficiaries only)

Submit This Form To The ICC Program Supervisor or Designee

FOR QUESTIONS REGARDING ICC REFERRALS
CONTACT the ICC Program Supervisor at:
PHONE: (925) 521-5732 • FAX: (925) 521-5658
or email: ICCreferrals@cchealth.org

NAME/MRN

ICC REFERRAL INFORMATION

Client's Current Address: _____

Current School: _____ Current Grade: _____

Current Caregiver: _____ Relationship: _____ Phone#: _____

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

CLIENT BEING REFERRED MUST MEET ALL OF THE FOLLOWING CRITERIA:

1 ☐ Has full scope Contra Costa (07) Medi-Cal and is under age 21 years.
2 ☐ Meets Medical Necessity criteria
3 ☐ Is receiving other specialty mental health services (TBS, Wraparound, individual therapy, specialized care rate)
4 ☐ Meets ICC eligibility criteria – Attach ICC Eligibility Evaluation (form MHC-300) to this referral.
5 ☐ Youth and Caregiver understand the necessity of participating in Child and Family Team meetings for ICC services to be provided.

POINT PERSON: _____ **PHONE:** _____

PROGRAM: _____ **FAX:** _____

APPROVED BY
CLINICIAN'S SUPERVISOR: _____ **PHONE:** _____

CAREGIVER
AGREEMENT TO PARTICIPATE: _____ **PHONE:** _____

(ICC Manager, Supervisor or Designee only) ☐ ***Medi-Cal verified***

Reason why client is being referred for ICC services (state specific reasons why ICC services will benefit the client):

DISPOSITION

☐ Child/Youth/Family has declined ICC services:

_____ _____
Assessment Declined by (Name of Person) ***Date Declined***

☐ ICC Program Assigned: _____

ICC Supervisor Signature/License/Designation **Printed Name** **Date**