CONTRA COSTA HEALTH
MENTAL HEALTH SERVICES

Intensive Care Coordination (ICC) Eligibility Evaluation

NAME / MRN

Facility Name: _____ ID: _____ Program Name: _____ ID: _____

Provider: _____ ID: _____ Service Date: _____

Service Category:

☐ CPT/HCPC Service Provided ☐ Lockout - CPT/HCPC Service Provided

☐ Other Nonbillable Service Provided:

☐ Money Management ☐ Providing transportation ☐ Leaving voicemails

☐ Coordination of logistics ☐ Clerical work ☐ Other _____

Direct Service Time (Min): _____ Documentation Time (Min): _____ Travel Time (Min): _____

Number in Group: _____ CPT/HCPC Code: _____

Location of Service (Please check one)

☐ Age-Specific Community Center ☐ Homeless/Emergency Shelter ☐ Phone–provided other than in client's home
☐ Client's Job Site ☐ Inpatient ☐ Residential Care - Adults
☐ Correctional Facility ☐ Mobile Service ☐ Residential Care - Children
☐ Faith-Based ☐ Non-Traditional service location ☐ School
☐ Field ☐ Office ☐ Telehealth/Video-provided in client's home
☐ Health Care/Primary Care ☐ Other Community Location ☐ Telehealth/Video-provided other than in Client's home
☐ Home ☐ Phone–provided in client's home ☐ Unknown/Not Reported

☐ Nontraditional Location ☐ Other _____ ☐ Unknown

Did this service involve interactive complexity? ☐ Yes ☐ No

Did this service include the interpretation of results and explanation to the client/family? ☐ Yes ☐ No

For Clients Under 21 only:

Is this an ICC Service? ☐ **Yes** ☐ **No** Is this service linked to a Child and Family Team? ☐ **Yes** ☐ **No**

COUNTY STAFF ONLY: Does this service fall under FFPSA (Qualified Individual? ☐ **Yes** ☐ **No**

☐ **Initial Determination** ☐ **General Re-evaluation** (as needed) ☐ **Annual** ☐ **90-Day Re-evaluation** (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

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- ☐ 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

NOTES:

- Any youth meeting eligibility for ICC is eligible (entitled) to IHBS. The assigned ICC along with the CFT members determines the need for IHBS and coordinates the timing of referral to IHBS with the beneficiary and the family.
- Therapeutic Foster Care (TFC) may also be an option that will be discussed in CFT meetings. If criteria are met (youth has full-scope Medi-Cal, risk of placement loss, recent history of intensive SMHS not providing enough support, and transitioning from STRTP, inpatient, or institutional setting to a community setting), the TFC Referral form must be completed. The referral will be triaged, verified, and finalized during the Interagency Placement Committee (IPC) meetings.

☐ **Client meets ICC eligibility criteria.**

If ICC-eligible, what is the child/youth's current living situation?

- ☐ Home with immediate family
- ☐ Home with extended family (relatives)
- ☐ Home with non-related persons
- ☐ Foster home
- ☐ Group home/TFC/STRTP
- ☐ Other: _____

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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:**

☐ Mutual team agreement ☐ Incarceration
☐ Presumptive transfer/Moved out of area ☐ Location unknown

☐ 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