CONTRA COSTA HEALTH
MENTAL HEALTH SERVICES

Intensive Home-Based Services (IHBS) Referral & Authorization

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: _____

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.	Current ICC Eligibility Evaluation Form (MHC-300)	☐	☐
3.	Current ICC 90-Day Eligibility Review/Progress Notes	☐	☐
4.	Most recent assessment (MHC-033)	☐	☐
5.	Current Problem List (MHC-018)	☐	☐
6.	Current Pediatric Symptom Checklist (PSC-35)	☐	☐
7.	Current CANS (MHC-118)	☐	☐

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	☐	☐
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: _____ DOB: _____

MRN: _____ Ethnicity: _____ Preferred Pronouns: _____

Gender: ☐ Male ☐ Female ☐ Transgender ☐ Non-binary

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 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:

NAME / MRN

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.)

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

Additional Notes: