CONTRA COSTA HEALTH
MENTAL HEALTH SERVICES

Intensive Care Coordination (ICC) Referral Request

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: _____

Intensive Care Coordination (ICC) is a medically necessary service and is similar to activities provided such 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 ongoing re-assessment and treatment planning, addresses the child's/youth's needs and strengths in the context of the values.

REFERRAL PACKET MUST INCLUDE:

☐ ICC Cover Sheet/ICC Referral Request (MHC-305, this form)

From the Chart:

☐ Copy of the client's most current assessment form (MHC-033 or MHC-100). (If the most current assessment is an annual assessment, please include the initial assessment as well)

☐ Current Child and Adolescent Needs and Strengths (CANS) (MHC-118)

☐ Pediatric Symptom Checklist (PSC-35) (MHC-120)

☐ Copy of current Problem List (MHC-018)

☐ Copy of the client's most current ICC Eligibility Evaluation (MHC-300)

Is client involved with CFS? Yes ☐ No ☐ Presumptive Transfer? Yes ☐ No ☐ _____
County of 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)

***Send this form with the referral packet via secure email to* ICCreferrals@cchealth.org**

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 criteria for specialty mental health services
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.

ICC services are generally offered to clients who receive care from multiple providers and/or agencies and who would benefit from cross-system coordination of care. Describe how ICC services would benefit the client's coordination of care.

Point Person: _____ Phone: _____

Program: _____ Fax: _____

Approved By
Clinician's Supervisor: _____ Phone: _____

Name Of Caregiver
Agreeing To Participate: _____ Phone: _____

(ICC Manager, Supervisor Or Designee Only) ☐ Medi-Cal Verified

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