INTENSIVE HOME BASED SERVICES (IHBS) REFERRAL & AUTHORIZATION FORM

Beneficiary Name: ________________________________  MRN: _______________

1. Completed IHBS Referral Form
2. ICC Eligibility Screening Form (Initial)
3. ICC 90-Day Eligibility Review/Progress Notes (Current Review)
4. Initial Assessment (MHC033)
5. Annual Assessment (MHC065-9) - if Initial is older than 6 months
6. Current Partnership Plan (MHC021-7)
7. Medical Necessity Form (MHC18-7)
8. CALOCUS (MHA091)/LOCUS (MHA092) - TAY age clients only
9. PSP Face Sheet (PSP MHS140)
10. Coordinated Services Form
11. DC 5A: Authorization for Medical Treatment
12. 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)
INTENSIVE HOME BASED SERVICES REFERRAL

Client’s Name: _______________________________ MRN: __________________

Gender: ☐ Male ☐ Female ☐ Transgender  DOB: _______________ Ethnicity: ______________________

Client Primary Language: ☐ Eng ☐ Span ☐ Other______  Family Primary Language: ☐ Eng ☐ Span ☐ 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 or Crisis Stabilization (PES), Crisis Intervention (PES/MRT)
☐ Group Home (RCL 10 or higher) or Short Term Residential Therapeutic Programs (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
☐ Two or more mental health hospitalizations in last 12 months
☐ Two or more emergency room visits in the last 6 month 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 month period
☐ Treated with one psychotropic medication, for child/youth 5 year 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 year 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
☐ 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 months
☐ Other: ____________________________
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 behaviors that interfere with the achievement of a stable and permanent family life:

3. Is there a transition plan in place?

4. If the child/youth is currently being served by existing EPSDT (WRAPAROUND/TBS) or other specialty mental health services how will the addition of IHBS benefit the client/youth/family?
Child/family would benefit from referral for:

☐ IHBS Family Partner (support primarily for the caregiver)
☐ IHBS Community Liaison (support primarily for the child/adolescent)

Child and Family Team Members (as of date of referral) - Names/Telephone Numbers/Email:

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:

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