ICC REFERRAL REQUEST

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 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.

SUBMIT TO ICC Program Supervisor or Designee

DATE: ______________________________

FROM: __________________________________________

Primary Clinician (Point Person) Referring Agency

ICC REFERRAL

(CHILD:) ______________________________

(MR #) ______________________________

REFERRAL PACKET MUST INCLUDE:

☐ ICC Cover Sheet/ICC Referral Form
☐ Facesheet
☐ Medi-cal Verification Report

From the Chart:

☐ Copy of the client’s most current Assessment Form (If there is an Annual assessment, please include the Initial Assessment as well)

☐ Copy of the client’s Partnership Plan – (Include the client’s referral for ICC services within the body of the partnership plan).

☐ Copy of Signed Consent for Coordinated Services or DC 5 A/B if CFS involved

☐ Service Authorization Form (green form)

☐ Copy of ICC Eligibility Screening Form

FOR QUESTIONS REGARDING ICC REFERRALS
CONTACT ICC Program Supervisor at:

PHONE: (925) 521-5743 • FAX: (925) 521-5658
ICC REFERRAL FORM

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 under age 21 years.
3. Is receiving other specialty mental health services (TBS, Wraparound, individual therapy, specialized care rate)
4. Meets ICC eligibility criteria – Attach ICC Eligibility Form to this referral.
5. Youth and Caregiver understand the necessity of participating in Child 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: ( _____ ) __________

☐ Medi-Cal verified

(DISPOSITION)

☐ Child/Youth/Family has declined ICC services: ______________________________________
   Assessment Declined by (Name of Person): ___________________________  Date Declined ________
   ICC/KTA Supervisor’s Signature/License/Designation __________________________
   Printed Name ______________________________________  Date __________

☐ ICC Program Assigned: ____________________________________________________
   ICC/KTA Supervisor’s Signature/License/Designation __________________________
   Printed Name ______________________________________  Date __________