

- 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 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 medical necessity criteria for ICC also meets criteria for 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 medical necessity criteria for ICC.

If medical necessity is established, what is the child/youth's current living situation?

- | | |
|--|---|
| <input type="checkbox"/> Home with immediate family | <input type="checkbox"/> Foster home |
| <input type="checkbox"/> Home with extended family (relatives) | <input type="checkbox"/> Group home/TFC/STRTP |
| <input type="checkbox"/> Home with non-related persons | <input type="checkbox"/> Other: _____ |

Client meets ICC eligibility criteria, but ICC referral is not requested at this time, due to Care Coordination needs being sufficiently met by:

- Targeted Case Management
- Enhanced Care Management
- Wraparound
- Other (Specify below)

Client meets medical necessity criteria for ICC, but SERVICES ARE CLOSING due to:

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

Other: _____

Medical necessity for ICC referral was not established.

For Initial Evaluation Services:

Client meets medical necessity criteria for ICC and has AGREED to ICC services.
(Submit ICC Referral form to ICCReferrals@cchealth.org for assignment)

Client meets medical necessity criteria for ICC, but child/youth/family has DECLINED ICC services:

Name of Person Declining ICC Services / Relationship to Client

Date Declined

Please indicate course of action. Select/fill out when medical necessity is not met or chosen:

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 client to be re-evaluated by (*must be within 90 days*):

Date

NAME / MRN _____

(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 client to be re-evaluated by *(must be within 90 days)*: _____
Date