



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
- Other Nonbillable Service Provided:
 - Money Management
 - Coordination of logistics
 - Providing transportation
 - Clerical work
 - Lockout - CPT/HCPC Service Provided
 - Leaving voicemails
 - Other _____

Direct Service Time (Min): _____ Number in Group: _____

Documentation Time (Min): _____ CPT/HCPC Code: _____

Travel Time (Min): _____

REFERRAL PACKET MUST INCLUDE:

- IHBS Referral and Authorization Form (MHC-302, this form)
- From the Chart:**
 - Copy of the client's most current assessment form (MHC-100). (If the most current assessment is an annual assessment, please include the initial assessment as well)
 - Current (must be done every 6 months) 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 Determination of Medical Necessity for ICC form (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)

Referral Packet Completed by: _____ Date: _____
(Signature Service Provider/Licensure/Designation)

(Printed Name Service Provider)

Reviewed by Referring Program Manager: _____ Date: _____
(Signature Program Manager/Licensure/Designation)

(Printed Name Program Manager)

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 INFORMATION

Client's Name: _____ DOB: _____

MRN: _____ Ethnicity: _____ Preferred Pronouns: _____

Gender: Male Female Transgender Non-binaryClient 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#: _____

To establish Medical Necessity Criteria for ICC/IHBS Services, the youth must meet criteria 1. and 2.

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 SMHS? Yes No
3. In addition, please identify complex needs. Please note that this list is not exhaustive. There may be other reasons why ICC/IHBS may be needed services (see "other" criterion").
Is the child currently receiving or being considered for any of the following service(s)? ***If so, check all that apply.*** Yes No

- 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:

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: