



# 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 similar to services 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) and CANS 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-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)

**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**

## ICC REFERRAL INFORMATION

Client's Current Address: \_\_\_\_\_

Current School: \_\_\_\_\_ Current Grade: \_\_\_\_\_

Current Caregiver: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone#: \_\_\_\_\_

Legally Responsible Party: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone#: \_\_\_\_\_

### **Required Medical Necessity Criteria for ICC:**

1.  Has full-scope Medi-Cal
2.  Meets Access Criteria for specialty mental health services

### **In Addition, Identify Complex Needs:**

3.  Is receiving other specialty mental health services (TBS, Wraparound, individual therapy, specialized care rate)
4.  Meets medical necessity criteria for ICC – Attach Determination of Medical Necessity for ICC (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. Provide specific details:***

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

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## DISPOSITION

- Child/Youth/Family has declined ICC services:

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Assessment Declined by (Name of Person)

\_\_\_\_\_

Date Declined

- ICC Program Assigned: \_\_\_\_\_

\_\_\_\_\_

ICC Supervisor Signature/License/Designation

\_\_\_\_\_

Printed Name

\_\_\_\_\_

Date