COUNTY OF SANTA CLARA
Behavioral Health Services

Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS) Screening and Service Request Form

BENEFICIARY INFORMATION		
Last Name:	First Name:	
Date of Birth:	Age:	
Ethnicity:	Gender:	Language:
Address:	Phone:	
Full-Scope Medi-Cal: ☐ Yes ☐ No	Verified Medi-Cal Number:	

PARENT OR LEGAL GUARDIAN INFORMATION		
☐ Mother ☐ Father ☐ Legal Guardian	Name:	Language:
Address:		Phone:

☐ Mother ☐ Father ☐ Legal Guardian	Name:	Language:
Address:		Phone:

INTENSIVE CARE COORDINATION (ICC)

ICC SCREENING
Screening Date:
Screening Conducted By:
Screening Program, Agency & Location:
Screening Type: ☐ Initial Evaluation ☐ Re-evaluation, please specify reason:

ICC Service Need is established if all of the following criteria (1-3) are met:	
1. Does the beneficiary have full scope Medi-Cal?	☐ Yes ☐ No (NOT ELIGIBLE FOR ICC)
2. Does the beneficiary meet Medical Necessity criteria?	☐ Yes ☐ No (NOT ELIGIBLE FOR ICC)
3. Does the beneficiary meet any one of the following? (Yes: at least one indicator applies; No: none applies)	☐ Yes ☐ No (NOT ELIGIBLE FOR ICC)

CHECK ALL THAT APPLY	☐ Involved with two or more supportive services from child-serving systems
	☐ Receiving or being considered for Wraparound
	☐ Being considered for intensive specialty mental health services (SMHS) or currently receiving crisis stabilization or intervention services
	☐ Currently in or being considered for Short Term Residential Therapeutic Programs (STRTPs)
	☐ Discharged within 90 days or currently being treated at a Psychiatric Hospital or Crisis Stabilization Unit (CSU)
	☐ Experienced two or more mental health hospitalizations in last 12 months
	☐ Experienced two or more placement or placement changes within 24 months due to behavioral health needs
	☐ Treated with two or more antipsychotic medications at the same time over a three (3) month period
	☐ Had two or more crisis encounters within the last six (6) months due to behavioral health concerns
	☐ Currently receiving SMHS and experiencing housing insecurity
	Age-Specific Indicators
	☐ (Age 0-5) Treated with more than one (1+) psychotropic medication
	☐ (Age 0-5) Diagnosed with more than one (1+) mental health diagnosis
	☐ (Age 6-11) Treated with more than two (2+) psychotropic medications
	☐ (Age 6-11) Diagnosed with more than two (2+) mental health diagnoses
	☐ (Age 12-17) Treated with more than three (3+) psychotropic medications
	☐ (Age 12-17) Diagnosed with more than three (3+) mental health diagnoses

ICC SCREENING OUTCOME		
Needing services?	☐ Yes, criteria met	☐ No, criteria not met (CONCLUDE FORM AND DOCUMENT)
Offered services?	☐ Yes, offered	☐ No, not offered (PROVIDE EXPLANATION IN NOTES)
Accepted services? (BENEFICIARY NOT RECEIVING ICC)	☐ Yes, accepted	☐ No, declined (CONCLUDE FORM AND DOCUMENT)
Continuing services? (BENEFICIARY ALREADY RECEIVING ICC)	☐ Yes, continuing	☐ No, discontinuing (PROCEED TO ICC NOTES)

Notes/Additional Information:

ICC SERVICE REQUEST (MUST BE COMPLETED IF BENEFICIARY MEETS CRITERIA AND ACCEPTS SERVICE)	
Request Date:	
Requesting Program & Agency:	
Request Made By:	Email Address:
Phone Number:	Fax Number:
Request Type: ☐ Internal (WITHIN PROGRAM) ☐ Internal (WITHIN AGENCY) ☐ External (TO OUTSIDE PROGRAM/AGENCY)	

Internal request: ICC services to be provided by your program or a program within your agency. If another program within your agency will provide ICC services, follow your internal agency procedures to provide ICC services to the beneficiary.
External request: ICC services to be provided by another agency. Follow the current interagency transfer process to identify and transfer beneficiary to an available program with ICC services; or under limited circumstances, coordinate with the receiving agency for adjunct services.

ICC DISPOSITION (MUST BE COMPLETED BY AN ICC COORDINATOR RECEIVING THE SERVICE REQUEST)	
Request Received Date:	Request Accepted Date:
Request Reviewed By:	Email Address:
Phone Number:	Fax Number:
Program & Agency Assigned:	☐ Same as requesting program and agency
ICC Coordinator Assigned:	☐ Same as service request reviewer

Notes/Additional Information: ☐ ICC being added as adjunct.

INTENSIVE HOME BASED SERVICES (IHBS)

Authorization request must be submitted to and approved by BHSD Utilization Management prior to the start of IHBS.

For new IHBS authorization requests, you must complete: (1) all sections of this form and (2) BHSD Utilization Management Authorization Request Form. Required information must be submitted to BHSD Utilization Management. For IHBS reauthorization requests, follow BHSD UM authorization request process.

Note: For beneficiaries in foster care, needs for Therapeutic Foster Care (TFC) must also be assessed.

IHBS SERVICE REQUEST (MUST BE COMPLETED BY AN ICC COORDINATOR)	
Request Date:	Request Completed By:
Start Date of ICC Services:	Date of IHBS Need Identified By CFT:
Date of Most Recent CFT Meeting:	Request Type: ☐ New (FOR NEW AUTHORIZATION REQUESTS ONLY)

Justification for IHBS Request
The beneficiary has and/or is currently experiencing: (CHECK ALL THAT APPLY)
☐ Functional impairment (challenges with functioning in the home and/or community)
☐ Developmental impairment (challenges with developmental progress)
☐ Social impairment (challenges with interaction with others)
☐ Probable significant deterioration (deterioration at home and/or community)
☐ Family instability (interference with having a stable and permanent family life)
☐ Housing instability (interference with maintaining housing)
☐ Educational challenges (interference with educational achievement)
☐ Employment instability (interference with seeking and maintaining a job)
☐ Other, please describe:

List mental health diagnosis and treatment goals and how IHBS will benefit the beneficiary:

Is an individualized treatment plan in place for the beneficiary?	☐ Yes ☐ No (NOT ELIGIBLE FOR IHBS)
Was IHBS agreed upon and accepted by the beneficiary and family?	☐ Yes ☐ No (NOT ELIGIBLE FOR IHBS)
Where will IHBS be delivered to beneficiary?	☐ Home ☐ Community ☐ Both

Notes/Additional Information:

Attestation		
☐ I attest that IHBS is a medically necessary service for this beneficiary.		
NAME OF LPHA	SIGNATURE	DATE
Date of IHBS Service Request Sent to BHSD UM:		