COUNTY OF SANTA CLARA
Behavioral Health Services

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

MEMBER 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 should be considered whenever clinically indicated. This includes, but is not limited to, the following circumstances.
• 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

ICC SCREENING (This screening is to help rule-in members who need ICC.)
Screening Date:
Screening Conducted By:
Screening Program, Agency & Location:
Screening Type: ☐ Initial Screening ☐ Re-screening, please specify reason:

ICC service is offered to full scope Medi-Cal members under age 21 in need of medically necessary SMHS.	
1. Does the member have full scope Medi-Cal?	☐ Yes ☐ No (REQUIRED FOR ICC)
2. Is SMHS medically necessary for the member?	☐ Yes ☐ No (REQUIRED FOR ICC)

→ Continue screening if both responses to above questions are "Yes"

ICC SCREENING OUTCOME (USE BELOW NOTE BOX TO DOCUMENT DETERMINATION AND DECISIONS)			
Based on your clinical assessment, is ICC service medically necessary?		☐ Yes (CONTINUE)	☐ No (CONCLUDE SCREENING & DOCUMENT)
If yes, ICC is needed	Discussed ICC service?	☐ Yes, discussed	☐ No, unable to discuss (DOCUMENT)
	Offered ICC service?	☐ Yes, offered	☐ No, not offered (DOCUMENT)
If yes, ICC was offered	(MEMBER NOT CURRENTLY RECEIVING ICC) Accepted ICC service?	☐ Yes, accepted	☐ No, declined (DOCUMENT)
	(COMPLETE ONLY IF MEMBER ALREADY RECEIVING ICC) Continue ICC service?	☐ Yes, continue	☐ No, discontinue (DOCUMENT)

Notes/Additional Information:

⬣ The next section must be completed when member is in need of ICC and accepts service. ⬣

ICC DISPOSITION

TO BE COMPLETED BY SCREENING PROGRAM	
Date of Completing Form to Coordinate Service:	
Program:	Agency:
Completed By:	Email Address:
Phone Number:	Fax Number:

ICC service type to be provided: ☐ Internal (WITHIN PROGRAM) ☐ Internal (WITHIN AGENCY) ☐ External (TO OUTSIDE PROGRAM/AGENCY)

Internal service: 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 member.
External service: ICC services to be provided by another agency. Follow the current interagency transfer process to identify and transfer member to an available program with ICC services, or under limited circumstances, coordinate with the receiving agency for adjunct services.

ICC to be added as adjunct: ☐ Yes ☐ No

ICC service may be added as an adjunct, **for case-by-case consideration**, with identified specialty programs and dependent on best clinical practice and the circumstance of the member, and as guided by their Child and Family Team.

Notes/Additional Information:

TO BE COMPLETED BY RECEIVING PROGRAM (PROGRAM TO PROVIDE ICC)	
Form Received Date:	
Program:	Agency:
Reviewed By:	Email Address:
Phone Number:	Fax Number:
ICC Coordinator Assigned:	
ICC to be added as adjunct.	☐ Yes ☐ No

Notes/Additional Information:

⬣ The next section is to be completed when IHBS is needed and by ICC/IHBS providers only. ⬣

For ICC/IHBS providers only: complete IHBS section when ICC and CFT are established and ongoing for the member.

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.

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: ☐ Prior authorization (FOR NEW REQUESTS ONLY)

Justification for IHBS Request
The member 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 member:

Is an ICC care plan in place for the member?	☐ Yes ☐ No (REQUIRED FOR IHBS)
Was IHBS agreed upon and accepted by the member and family?	☐ Yes ☐ No (REQUIRED FOR IHBS)

Notes/Additional Information:

Attestation
☐ I attest that IHBS is a medically necessary service for this member.
NAME OF LPHA (CREDENTIALS & LICENSE NUMBER) SIGNATURE DATE
Date of IHBS Service Request Sent to BHSD UM: