COUNTY OF SANTA CLARA
Behavioral Health Services

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

BENEFICIARY INFORMATION			
Name (FIRST AND LAST):			
Date of Birth:	Age:	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? Check all indicators that apply	☐ Yes ☐ No (NOT ELIGIBLE FOR ICC)
☐ 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 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 twelve (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 6-11	☐ Treated with more than two (2+) psychotropic medications	Age 12-17	☐ Treated with more than three (3+) psychotropic medications
	☐ Diagnosed with more than one (1+) mental health diagnosis		☐ Diagnosed with more than two (2+) mental health diagnoses		☐ 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? (BENEFICARY NOT RECEIVING ICC)	☐ Yes, accepted	☐ No, declined (CONCLUDE FORM AND DOCUMENT)
Continuing services? (BENEFICARY 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)

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 at email BHSDUM@hhs.sccgov.org

For IHBS reauthorization requests, follow BHSD UM authorization request process.

IHBS SERVICE REQUEST (MUST BE COMPLETED BY AN ICC COORDINATOR)	
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

Attestation
Name of Individual Who Completed the IHBS Service Request Section:
Date of IHBS Service Request Section Completion:
Date of IHBS Service Request Sent to BHSD UM:

Reminder: submit this form and the CSC BHSD Utilization Management Authorization Request Form to BHSD Utilization Management at BHSDUM@hhs.sccgov.org