NAME/MRN

INTENSIVE HOME BASED SERVICES (IHBS)
12 MONTH TREATMENT REVIEW
JUSTIFICATION FOR EXTENSION OF SERVICES

IHBS OPENING DATE: ____________________ 9-MONTH REVIEW COMPLETED ON: ________________

Client's Name: ____ MRN: __________________

Gender: ☐ Male ☐ Female ☐ Transgender DOB: _______________ Ethnicity: _________________________

Client Primary Language: ☐Eng ☐Span ☐Other_______ Family Primary Language: ☐Eng ☐Span ☐Other_______

Client's Current Address: ____

Current School: _______________________________ Current Grade: _______ ☐ Special Ed

Current Caregiver: _______________________________ Relationship: ____________ Phone#: __________

Legally Responsible Party: __________________________ Relationship: ____________ Phone#: __________

IHBS Staff Assigned: ___________________________ IHBS Program: ____________________________

Does the above mentioned child/youth have an *open* Child Welfare Case? ☐ Yes ☐ No

ICC Eligibility is established if **ALL** of the following criteria (1-3) are met:

1. Does the above mentioned child/youth have full scope Medi-Cal? ☐ Yes ☐ No
2. Does the above mentioned child/youth meet Medical Necessity criteria? ☐ Yes ☐ No
3. Is the child currently receiving or being considered for any of the following service(s): ☐ Yes ☐ No

   Check all that apply:

   ☐ Wraparound
   ☐ Specialized Care Rate due to Behavioral Health Needs
   ☐ Receiving intensive SMHS, including but not limited to Therapeutic Behavioral Services or Crisis Stabilization (PES), Crisis Intervention (PES/MRT)
   ☐ Group Home (RCL 10 or higher) or Short Term Residential Therapeutic Programs (STRTP)
   ☐ Experienced two (2) or more placements due to behavioral health needs in the past 24 months
   ☐ Psychiatric Hospital/24 Hour Mental Health Facility or discharged within past 90 days
   ☐ Two or more mental health hospitalizations in last 12 months
   ☐ Two or more emergency room visits in the last 6 month due to primary mental health condition 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 three month period
   ☐ Treated with one psychotropic medication, for child/youth 5 year 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 year 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
   ☐ Have been detained pursuant to W&I sections 601 and 602 primarily due to mental health needs
   ☐ Have received SMHS within the last year and have been reported homeless within the prior six months

   ☐ Other: ____

MRN/NAME

1. Please provide a summary of the IHBS services provided, including interventions utilized, the family's response to the interventions, and factors impeding or benefitting IHBS treatment provision.

2. Provide justification for continued service authorization for clients in program over 12 months?

3. What is the termination plan? Please provide clearly established timelines including requested length of extension.

4. What is the planned date of termination of IHBS? ______________________________

☐ Attach most current ICC Eligibility Form

______________________________	______________________________	__________
Signature/License/Designation	Printed Name	Date
______________________________	______________________________	__________
Co-Signature/License/Designation	Printed Name	Date

COUNTY AUTHORIZATION:

☐ Length of Authorization: ______ months   Authorization Period: ________ to ________
(start date) (end date)

☐ Extension Denied/NOA C issued

______________________________	______________________________	__________
Program Chief/Designee Signature	Printed Name	Date

Notification Sent: ______________________
Date/Initials