Intensive Care Coordination (ICC) Eligibility Evaluation

NAME / MRN

Date: ________________ Minute(s): ________________ Service Code: ☐ **314** ICC Evaluation ☐ **540** Non-Bill

Provider Name: ____________________________________ Provider #: ______________________

Program Name: ____________________________________ FAC/PROG: ______________________

Place of Service (check one)

☐Office	☐Inpatient Psychiatric	☐Residential Txt Center (Child)	☐ Telehealth – Pt Home
☐Field	☐Inpatient Health	☐Residential Txt Center (Adult)	☐ Telehealth – Other than Pt Home
☐Phone	☐Emergency Room	☐Hospice	☐Age Specialty Center
☐Home	☐Jail	☐Skilled Nursing Facility	☐Faith Based Location
☐School	☐Emergency Shelter	☐Mobile Service	☐Nontraditional Location
☐Satellite	☐Primary Care Health Clinic	☐ Job Site	☐Other Location

☐ **Initial Determination** ☐ **General Re-evaluation** (as needed) ☐ **Annual** ☐ **90-Day Re-evaluation** (For ICC use only)

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

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

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)? ***If so, check all that apply***. ☐ Yes ☐ No

- ☐ Wraparound
- ☐ Specialized Care Rate due to Behavioral Health Needs (Extra aid to some families w/foster youth)
- ☐ 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 Program (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 twelve (12) months
- ☐ Two or more emergency room visits in the last six (6) months 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 (3)-month period
- ☐ Treated with one psychotropic medication, for child/youth age 5 years or 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 age 5 years or 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 (6) months
- ☐ Other:

<u>NOTE</u>: Any youth meeting eligibility for ICC is eligible (entitled) to IHBS. The assigned ICC along with the CFT members determines the need for IHBS and coordinates the timing of referral to IHBS with the beneficiary and the family.

NAME/MRN

Additional Comments:

DETERMINATION

☐ **Client meets ICC eligibility criteria.**
If ICC-eligible, what is the child/youth's current living situation?

- ☐ Home with immediate family
- ☐ Home with extended family (relatives)
- ☐ Home with non-related persons
- ☐ Foster home
- ☐ Group home
- ☐ Other: ____________________

For Initial Evaluation Services:

☐ **Client meets ICC eligibility criteria and has AGREED to ICC services.**
(Submit ICC Referral form to ICCReferrals@cchealth.org for assignment)

☐ **Client meets ICC eligibility criteria, but child/youth/family has DECLINED ICC services:**

____________________ ____________________
Name of Person Declining ICC Services / Relationship to Client ***Date Declined***

☐ **Client meets ICC eligibility criteria, but SERVICES ARE CLOSING due to:**

- ☐ Mutual team agreement
- ☐ Presumptive transfer/Moved out of area
- ☐ Incarceration
- ☐ Location unknown
- ☐ Other: ____________________

☐ **Client does NOT meet ICC eligibility. Please indicate course of action:**

- ☐ Referral to MH Liaison ***(CFS-involved beneficiaries only)***:

____
Liaison Name/Region

- ☐ Referral to other: ____________________
- ☐ No referral needed

____________________ ____________________ ____________________
Assessor's Signature/License/Designation ***Printed Name*** ***Date***

NAME/MRN

<u>For Continuing ICC Services</u>: (For ICC use only)

☐ **ICC services continuing:**

Determined by: ____ ______________
ICC's Signature/License/Designation ***Date***

☐ Date eligibility to be re-evaluated by *(must be within 90 days)*: ______________
Date

(This section to be completed by the County ICC's supervisor or their designee at initial ICC assignment)

DISPOSITION

☐ ICC assigned: ____
Program/Agency

________________________________ ________________________________ ______________
ICC Supervisor's Signature/License/Designation ***Printed Name*** ***Date***

☐ Date eligibility to be re-evaluated by *(must be within 90 days)*: ______________
Date