CONTRA COSTA HEALTH
MENTAL HEALTH SERVICES

JUSTIFICATION FOR EXTENSION OF INTENSIVE HOME-BASED SERVICES (IHBS)

NAME / MRN _____

Client's DOB: _____ Ethnicity: _____ IHBS OPENING DATE: _____

Gender: ☐ Male ☐ Female ☐ Transgender ☐ Other _____ Preferred Pronouns: _____

Client's Primary Language: ☐ Eng ☐ Span ☐ Other _____

Family's 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

Has the above-mentioned child/youth been Presumptively transferred? ☐ Yes ☐ No **County:** _____

Eligibility Verification

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 access criteria? ☐ Yes ☐ No
3. Is the child currently receiving or being considered for any of the following service(s) (check all that apply)? ☐ Yes ☐ No

   ☐ Wraparound.
   ☐ Specialized care rate due to behavioral health needs.
   ☐ Receiving intensive SMHS, including, but not limited to, Therapeutic Behavioral Services (TBS), Crisis Stabilization (PES), or Crisis Intervention (PES/MRT).
   ☐ Group Home (RCL 10 or higher) or Short Term Residential Therapeutic Program (STRTP).
   ☐ Experienced two (2) or more placements in the past 24 months due to behavioral health needs.
   ☐ Psychiatric hospital/24-Hour mental health facility or discharged within the last 90 days.
   ☐ Two or more mental health hospitalizations in the last 12 months.
   ☐ Two or more emergency room visits in the last six (6) months due to a primary mental health condition, including, but not limited to, involuntary treatment under California Welfare and Institution Code section 5585.50.
   ☐ Treated with two (2) or more antipsychotic medications at the same time over at least a three (3) month period.
   ☐ Child/Youth aged 5 years or younger treated with one (1) psychotropic medication.
   ☐ Child/Youth aged 6-11 years treated with two (2) psychotropic medications.
   ☐ Child/Youth aged 12-17 years treated with three (3) psychotropic medications.
   ☐ Child/Youth aged 5 years or younger diagnosed with more than one (1) mental health diagnosis.

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☐ Child/Youth aged 6-11 years diagnosed with more than two (2) mental health diagnoses.
☐ Child/Youth aged 12-17 years diagnosed with more than three (3) mental health diagnoses.
☐ Has been detained pursuant to W&I sections 601 and 602 primarily due to mental health needs.
☐ Has received SMHS within the last year and has been reported homeless within the prior six (6) months.
☐ Other: _____

Treatment Review

1. Please summarize the IHBS services provided, including interventions utilized, the family's response to the interventions, and factors impeding or benefitting provision of IHBS services. List the progress made over the past 12 months.

2. If needed, provide justification for short-term continued service authorization for clients in the program for 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
_____	_____	_____
Signature/License/Designation	Printed Name	Date

NAME / MRN _____

COUNTY AUTHORIZATION:

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

☐ Extension Denied/NOABD issued

Signature/License/Designation	Printed Name	Date
_____	_____	_____
_____	_____	_____

Notification Sent: _____
Date/Initials