Santa Barbara County Department of Behavioral Wellness

Behavioral Wellness Request for Intensive Home Based Services (IHBS)

Please TYPE, fill out completely, and attach release of information (ROI)

Submit all documents to:
bwellqcm@sbcbwell.org

Please allow up to 5 business days for the request to be processed

Referring Party Information:

Date of Referral:
Mental Health Provider's Name:
Phone Number:

Client Information:

Client Name:
Client ID:
DOB:
Preferred Language:

IHBS:

Request: Re-authoriza

Service Criteria for IHBS

Must meet ALL of the following criteria: (check all that apply)	
☐	Child/Youth is under the age of 21;
☐	Child/Youth is eligible for full scope Medi-Cal services;
☐	Child/Youth meet medical necessity criteria for Specialty Mental health Services (SMHS);
☐	Primary clinician in place and is currently receiving services;
☐	Involved in more than one child-serving system in addition to Mental Health (e.g. Probation, Special Education, Drug & Alcohol, California Children's Services) or has multiple mental health providers; and

☐	Intensive level of care coordination is needed and cannot be adequately provided under standard mental health case management services. *(Standard services such as, individual/family therapy and rehabilitation)*
AND at least ONE of the following criteria, 1-5: *(check all that apply)*	
☐	1. Are receiving, or being considered for one of the following: SPIRT
☐	**2.** Are currently in, or being considered for, high-level-care institutional settings, such as group homes or Short-Term Residential Therapeutic Programs (STRTPs). *(When selecting "being considered for" prior and consistent documentation must reflect symptoms/behaviors leading to placing the child/youth at risk for placement in higher level of care.):* Consideration
☐	**3.** Have been discharged within 90 days, or currently reside in, or are being considered for placement in, a psychiatric hospital or 24-hour mental health treatment facility. *(When selecting "being considered for" documentation must reflect symptoms/behaviors leading to placing the child/youth at risk for placement in higher level of care.) :* Considered
☐	**4.** Have experienced two or more mental health hospitalizations in the last 12 months.
	Provide dates of hospitalizations:
☐	**5.** Have experienced two or more placement changes, within 24 months, due to documented behavioral health needs.
	Provide names of placements:

Please describe <u>specifically</u> the child/youth's circumstance and behaviors that require Intensive Care Coordination beyond what is provided under standard mental health case management:
Significant history or area of need affecting behavior(s): (check all that apply, comments)
☐ Trauma History:
☐ Family/Social:
☐ Substance Use:
☐ Medical Problems:

To be completed and signed by current specialty mental health provider:
☐ If this child/youth/young adult is authorized for ICC/IHBS services I agree to collaborate with ICC/IHBS provider, which will include regular participation in the Child and Family Team and associated team meetings and associated team meetings. I will write Intensive Care Coordination (ICC) into my treatment plan as an intervention. I have attached a copy of my current assessment, treatment plan, ROI, and Medi-Cal eligibility for this client.
Mental health provider's electronic signature:
Supervisor's electronic signature:
NOTE: If referring party is not the primary specialty mental health provider, check box below:
☐ Primary specialty mental health provider has been notified of this referral, and has been asked to send current mental health assessment, treatment plan, ROI, and Medi-Cal eligibility in order to complete this referral. **This referral cannot be processed until documentation is complete.**

This Section to be Completed by Regional Manager	
Approved: No	
If no, provide reason denied:	
Amount of days/months approved for:	
Start Date:	End Date:
Regional Manager's electronic signature:	