FRESNO COUNTY MENTAL HEALTH PLAN

Intensive Home-Based Services (IHBS) Authorization Request Form

***IHBS request must include the current assessment, CANS, and client plan**

***Complete form and attach current assessment, CANS, client plan with IHBS to support medical necessity**

Child's Name: _____ Medi-Cal ID: _____

Date of Birth: _____ Age _____ Gender: _____

Primary Caregiver: _____ Phone: _____

Relationship: ☐ Bio ☐ Foster ☐ Step ☐ Adoptive Katie A. Subclass YES ☐ NO ☐

Accurate Address: _____ City: _____ Zip: _____

Requested Effective date: _____

**Requested effective date not be dated prior to client plan authorization*

Please identify the following:

1. Does child have Full Scope Medi-Cal? ☐ Yes ☐ No County Code: _____ Aid Code: _____

2. Is child currently receiving EPSDT services (**E**arly **P**eriodic **S**creening, **D**iagnosis & **T**reatment services)? ☐ Yes ☐ No

☐ Therapy ☐ Medication ☐ Other: _____ Diagnosis: _____

THERAPIST	COUNTY SOCIALWORKER	PROBATION OFFICER
Name:	Name:	Name:
Phone:	Phone:	Phone:
Email:	Email:	Email:

3. Please list current medications and name of MD/psychiatrist:

To meet criteria for IHBS, #4, #5, and #6 must be indicated with "yes":

4. Has there been a Child Family Team meeting *and* ICC Plan documented within the most recent 90 days? ☐ Yes ☐ No

5. Is there an identified Intensive Care Coordination Coordinator? Name: ☐ Yes ☐ No

6. Has the child, family, and Child Family Team agreed to IHBS implementation? ☐ Yes ☐ No

7. Is there a provider(s) identified as able to implement IHBS at the proposed frequency and intensity? ☐ Yes ☐ No

Name of provider(s) or agency: _____

8. Has the child previously received IHBS? ☐ Yes ☐ No

IHBS services will address behaviors in at least one of the following areas (briefly and specifically explain):

☐ Stable & Permanent Family Life Explain:
☐ Stable Housing and/or independent living Explain:
☐ Obtain and Maintain Employment Explain:
☐ Achieve Educational Objectives Explain:

POSSIBLE IHBS INTERVENTIONS:

☐ Positive behavior plan
☐ Modeling for child & family
☐ Improve self-care
☐ Enhance self-regulation
☐ Decrease or replace non-functional behaviors Explain:
☐ Avoid exploitation by others
☐ Improving self-administering of medications
☐ Educate child & family on managing symptoms
☐ Enhance use of natural and community supports
☐ Enhance participation in CFT meetings
☐ Other:

Print Name Title; Agency	**Fax Number:**

☐ **Acknowledgment required**	**By checking this box, I am indicating that I understand approval of authorization does not guarantee payment, and that all services may be subject to retrospective review.**

****Incomplete IHBS referral packets cannot be processed.*** *Please fax or email all items together (IHBS Referral form, signed copy of clinical assessment, signed copy of treatment plan that includes the intervention of IHBS, and CANS) to Managed Care at Fax:(559)455-4633 or Email: DBHAuthorizations@fresnocountyca.gov*

Therapist's Signature_____ **Date** _____