KINGS COUNTY MENTAL HEALTH PLAN

Intensive Home Based Services (IHBS) REFERRAL Form

Fax referral packet to KCBH: 559-589-6928 or Email to: kingsMHPcsoc@co.kings.ca.us

*IHBS MUST be added to current Treatment Plan *Referral MUST include most current full assessment

*Please complete all items and include latest complete assessment, Plan of Care, Three Most Recent Progress Notes, A signed Release of Information, and Diagnosis Form.

Child's Name:_____ Medi-Cal No. : _____

Date of Birth:_____ Age_____ Gender Identity:_____

Primary Caregiver:_____ Phone:_____

Relationship: ☐ Bio ☐ Foster ☐ Step ☐ Adoptive ☐ Other_____

Accurate Address:_____ City:_____ Zip:_____

Ethnicity:_____ Caregiver's Preferred Language:_____ Preferred service time:_____

School: Grade: IEP Yes ☐ No ☐ Enrolled ☐ Suspended/Expelled ☐

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)

☐ Is child currently receiving EPSDT services (Early Periodic Screening Diagnosis)

☐ 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

☐ 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)

THERAPIST	COUNTY SOCIAL WORKER	PROBATION OFFICER
Name:	Name:	Name:
Phone:	Phone:	Phone:
Email:	Email:	Email:

Please list current medications and name of MD/psychiatrist:_____

List hospitalizations in psychiatric facility and dates (if any): _____

Has child/youth received IHBS in the past: ☐ Yes ☐ No

Must be receiving Intensive Care Coordination

ICC eligibility met (include most recent ICC eligibility screening form): ☐ Yes ☐ No

ICC Coordinator/Agency: Name_____ Agency_____

Phone_____ Email_____

Date of last CFT_____

CURRENT PROBLEM BEHAVIORS that are jeopardizing placement or transition

☐ Self injurious behavior
☐ Threat to others
☐ Withdrawal, isolates self
☐ Disregard for rules
☐ Property damage
☐ Verbal aggression
☐ Physical aggression
☐ other
☐ Has made allegations of abuse in past
Explain:

POSSIBLE AREAS of FOCUS

☐ Increasing coping strategies
☐ Increasing social skills
☐ increasing daily living skills
☐ increasing school functioning
☐ Sexual behaviors Explain:
☐ Decreasing opposition/defiance
☐ Decreasing self-injurious behaviors
☐ Decreasing property damage
☐ Decreasing verbal/physical aggression
☐ Community integration
☐ Other:

Print Name Title; Agency	Fax Number:
☐ Expedited Referral	Rational: