Alameda County BHCS ICC Referral Form

PLEASE FAX COMPLETED FORM TO 1-866-492-4734

Youth's Last Name: _______________________ First Name: ____________________ DOB: ___ / ___ / ____

Street Address: ____ City: ____________________ Zip Code: _________

Medi-Cal #: _________________________ Preferred Language: ________________

School: _________________________ Grade: _____ IEP? Y or N School Contact/#: ____________________________

Service Criteria for ICC

Child/Youth/Young Adult (under 21) must meet both of the following criteria:

☐ Primary Mental Health clinician in place and is currently receiving services; **and**

☐ Involved in one or more child-serving system in addition to Mental Health (e.g. Probation, Special Education, Drug & Alcohol, Regional Center, crisis shelter, California Children's Services) or has multiple mental health providers;

And at least ONE or more of the following criteria, 1-6: *(check all that apply)*

☐ **1.** In or being considered for one of the following Intensive Specialty Mental Health Services:

☐ TBS ☐ Level 1 ☐ Non Public School CESDC

☐ Therapeutic Nursery ☐ Counseling Enriched Special Day

☐ **2.** Currently placed in a group home with a planned discharge within 30 days,* or discharged from group home within the preceding 90 days, *or being considered for* group home placement (RCL 10 +) or STRTP. (*For the "being considered for" element of group home placement, only Deputy Probation Officers, or Special Education ERMHS clinicians may select this criteria in referrals.)*

☐ **3.** Currently in a crisis stabilization unit or crisis residential treatment with a planned discharge within 30 days, or discharged from crisis stabilization unit or crisis residential treatment** within the preceding 90 days. *(e.g., Willow Rock Crisis Stabilization Unit, John George Pavilion Psychiatric Emergency Services, Woodrow Place, Jay Mahler Recovery Center.)*

☐ **4.** Currently in a crisis shelter, or discharged from a crisis center within the preceding 90 days. *(e.g., Dreamcatcher, Diamond Youth Shelter, Covenant House and other adult shelters that TAY under 21 may utilize.)*

☐ **5.** Currently in a Mental Health Rehabilitation Center with a planned discharge within 30 days, or discharged from a Mental Health Rehabilitation Center,* within the preceding 90 days. *(e.g., Villa Fairmont, Gladman, Garfield Subacute Psychiatric Inpatient.)*

☐ **6.** Currently in a psychiatric hospital with a planned discharge within 30 days, or discharged from a psychiatric hospital within the preceding 90 days.

☐ **7.** Intensive level of care coordination is needed and cannot be adequately provided under standard mental health case management services.

Please describe specifically the client's circumstances & behaviors that require Intensive Care Coordination beyond what is provided under standard mental health case management:

____

____

____

____

Youth Resides with: [ ] Parent [ ] Relative/Fictive Kin [ ] Group Home [ ] SILP [ ] Other: _______________

Caregiver's Name(s): ___________________________________Phone #: (____) ____________ Alt. Phone #: (____) ________

Caregiver Preferred Language: ___________________________ Understands English Y or N

Caregiver's Name(s): ___________________________________Phone #: (____) ____________ Alt. Phone #: (____) ________

Caregiver Preferred Language: ___________________________ Understands English Y or N

GH name: _________________________ GH Contact Person: _________________ Planned Discharge Date: ______________

For group home placement, ICC services are only available 30 days prior to discharge.

(Medication) Prescribing Provider: _______________________________________ Phone #: (_____)_________________

RELEVANT CULTURAL FACTORS: ____

IMMEDIATE SAFETY CONCERNS/RISK FACTORS: [ ] Danger to Self or Others [ ] Commercially Sexually Exploited Youth

If referring party is not the primary specialty mental health provider, check boxes below:

- ☐ Primary specialty mental health provider has been notified of this referral
- ☐ Primary specialty mental health provider has been asked to fax the current mental health assessment to the BHCS ICC Administrator at **1-866-492-4734**

If referring party is the primary specialty mental health provider please fax current mental health assessment with this referral form

Significant history or area of need affecting behavior(s): (check all that apply, comments)

☐ Trauma History ____

☐ Family/Social ____

☐ Substance Use ____

☐ Medical Conditions ____

Contact Information

(To be submitted with referral)

Client information will be exchanged among participants of designated partner agencies who are involved in delivering this comprehensive service as a collaborative team. Information disclosed by you, the youth, or other family members and natural supports while participating in ICC services is generally confidential, unless exceptions to confidentiality apply. Exceptions to confidentiality include (but are not limited to) reporting suspected child abuse or expressed threats of violence towards self or an identifiable victim, and certain legal proceedings.

Please **write-in the name of person/agencies** involved in your child/youth's comprehensive treatment. This will allow the ICC provider to make initial contact in forming the care coordination team.

Mental Health Provider ____ Phone: ________________________________
Mental Health Provider ____ Phone: ________________________________
Primary Care Physician ____ Phone: ________________________________
Relative/Natural Supports ____ Phone: ________________________________
Probation Officer ____ Phone: ________________________________
ERMHS Case Manager ____ Phone: ________________________________
Regional Center Case Manager ____________________________________ Phone: ________________________________
School Staff ____ Phone: ________________________________
TBS Staff ____ Phone: ________________________________
Other (specify role) ____ Phone: ________________________________
Other (specify role) ____ Phone: ________________________________

Release of Information

Please sign if you are the parent or legal representative and are authorizing release and exchange of information to/from the ICC Provider and the above contacts. This disclosure will allow exchanging information with the collaborative team members to appropriately plan for ICC related services. This release is subject to revocation by the undersigned at any time and if not earlier revoked, shall terminate one year from the date of signing this release.

____
Printed Name of Child/ Youth

☐ **Parent** _______________________________________ **Phone** ________________________

Signature:_______________________________________ **Print Name:**______________________
(Parent/Legal Rep, Client over 18, or Minor) (Parent/Legal Rep, Client over 18, or Minor)

Signature of Client: ___________________________________ **Date**: ___________________________

If client refuses or is unavailable, please explain ____

Consent for ICC

I give consent for ____ to receive ICC services.

Signed ________________________________ Print Name __________________________ Date_____________
(Parent/Legal Rep, Client over 18, or Minor) (Parent/Legal Rep, Client over 18, or Minor)

This consent is subject to revocation by the undersigned at any time and if not earlier revoked, and shall terminate one year from the date of signing this release.