alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

2000 Embarcadero Cove, Suite 400
Oakland, Ca 94606
510-567-8100 / TTY 510-533-5018
Karyn L. Tribble, PsyD, LCSW

Intensive Care Coordination (ICC) Referral Form

PLEASE FAX COMPLETED FORM TO 1-866-313-8448

Contact ACBH ICC/IHBS Coordinator at (510) 383-5128 for information

*This form is **NOT** to be used for open **Child Welfare** cases.*
For child welfare clients, please consult with Child Welfare Worker regarding a Katie A. referral

Date _____ Person Referring _____ Relationship to Client _____

Phone# _____ email _____

Youth's First Name _____ Last Name _____ DOB _____

Youth's address _____ City _____ Zip code _____

Medi- Cal# _____ Youth's phone number _____

Preferred Language: ○ English ◉ Spanish ○ Other _____

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

Caregiver: ☐ Parent ☐ Relative/Fictive Kin ☐ STRTP ☐ Other: _____

Caregiver's Name: _____ Phone # _____ Alt Phone# _____

Caregiver Preferred Language: _____ Understands English ☐ Yes ☐ No

STRTP name: _____

STRTP Contact Person: Planned Discharge Date:

Child/youth has full scope Medi-Cal	☐ Yes	☐ No
Client is age birth to 21	☐ Yes	☐ No
Intensive level of care coordination is needed and cannot be adequately provided under standard mental health case management services	☐ Yes	☐ No

Please indicate if any of the following apply:(NOTE: these are not eligibility criteria)
Child / Youth is / has:

- ☐ Receiving/being considered for intensive mental health services, including but not limited to Therapeutic Behavioral Services, Therapeutic Foster Care, Crisis Stabilization, Crisis Intervention, or Wrap/Project Permanence
- ☐ In psychiatric hospital/24 hour mental health facility or discharged within past 90 days
- ☐ Two or more mental health hospitalizations in last 12 months
- ☐ Treated with one or more psychotropic medications over the past year
- ☐ Been detained pursuant to W&I sections 601 and 602 primarily due to mental health needs
- ☐ Received Specialty Mental Health Services (SMHS) within the last year and has been reported homeless within the prior six months

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

RELEVANT CULTURAL FACTORS: _____

IMMEDIATE SAFETY CONCERNS / RISK FACTORS:

☐ Danger to Self or Others ☐ Commercially Sexually Exploited Youth

Child and Family Team Members (as of date of referral) – if available			
Team Member	**Name**	**Telephone#**	**email**
Mother(s):			
Father(s):			
Social Worker			
Therapist			
TBS Worker:			
Family Partner:			
Other (please specify):			

Additional Comments: