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 Home Based Services (IHBS)
Referral and Authorization Form

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

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

Date: Person Referring: Agency Name:

Phone# email:

Client's First Name: Last Name: PSP#

Gender: ☐ Male ☐ Female ☐ Transgender Other: DOB:

Ethnicity: Preferred Pronouns:

Client's Primary Language ☐ English ☐ Spanish ☐ Other:

Family Primary Language ☐ English ☐ Spanish ☐ Other:

Client's Current Address: Client Phone#

City: Zip Code:

Current School Current Grade: ☐ Special Ed

Current Caregiver: Relationship Phone#

Name of Legally Responsible Party: Relationship:

Phone#

Date of most recent ICC Service:

Date of CFT meeting that recommended IHBS referral:

JUSTIFICATION FOR IHBS

For the purposes of verifying medical necessity for SMHS the following supporting document is required with this IHBS referral:

Mental health treatment plan completed within the last year that identifies IHBS as an intervention.

1. Describe the behaviors that interfere with the achievement of a stable and permanent family life:

2. Describe in detail the behavior(s) or mental health conditions that interfere with the youth's functioning in the home and/or the community:

eg. Describe behaviors that interfere with youth's independent living objectives in terms of:

- Achieving youth educational objectives in an academic program in the community or
- Seeking and maintaining a job

3. How will IHBS support the ICC treatment plan goals?

4. If the youth is currently being served by an existing EPSDT or other specialty mental health services how will the addition of IHBS benefit the youth/family?

Child and Family Team Members (as of date of referral) – if available			
Team Member	**Name**	**Telephone#**	**email**
Intensive Care Coordinator (ICC):			
Mother(s):			
Father(s):			
Social Worker			
Foster Parent(s):			
Non-relative Extended Family Member (NREFM) or Guardian			
Therapist			
TBS Worker:			
Family Partner:			
Group Home Contact:			
EBCLO Attorney:			
Other (please specify):			

---

for office use only

ACBH DETERMINATION

☐ Client meets IHBS Eligibility criteria

☐ Client does NOT meet IHBS criteria

Reason(s): ____

______________________ ______________________ ______________

ACBH Administrator Signature **Printed Name** **Date**