



## Intensive Home Based Services (IHBS) Referral and Authorization Form

**Instructions:**

- Please complete this form.
- Attach the most recent **ICC/IHBS Child and Family Team (CFT) Client Care Plan and Meeting Minutes form.**
- Email the completed packet or any questions to [ICCAdministrator@acgov.org](mailto:ICCAdministrator@acgov.org)

Date:		Person Referring:		Agency	
Phone#		Email:			

### CLIENT INFORMATION

Client's First Name:								Last Name:									
<b>GENDER IDENTITY</b>								SmartCare#									
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:																	
City:				Zip Code:				Client Phone#									
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

**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 school 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/IHBS Client Care Plan goals?**

**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			
STRTP/Group Home Contact			
EBCLO Attorney			
Other (please specify)			

*(For office use only)*

**ACBH DETERMINATION**

Client meets IHBS Eligibility criteria. Approval dates: \_\_\_\_\_

Client does NOT meet IHBS criteria

**Reason(s):**

\_\_\_\_\_  
**ACBH Administrator Signature**

\_\_\_\_\_  
**Printed Name**

\_\_\_\_\_  
**Date**