



## Eligibility Screening Form: ICC Services

Client Name: \_\_\_\_\_ DOB: \_\_\_\_\_ MHN: \_\_\_\_\_

Gender: \_\_\_\_\_ Pronouns: \_\_\_\_\_ Race/Ethnicity: \_\_\_\_\_

Language: \_\_\_\_\_ Medi-Cal #: \_\_\_\_\_ Issue Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Caregiver Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Language: \_\_\_\_\_

Caregiver Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Language: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

1. Does the child/youth/young adult (age 0-20) have full-scope Medi-Cal?  YES  NO
2. Does the child/youth/young adult (0-20) meet medical necessity for Specialty MH Services (SMHS)?  YES  NO  
 If **YES**, see current MH Assessment dated \_\_\_\_\_ or CANS dated \_\_\_\_\_
3. Do any of the following apply to the child/youth/young adult (age 0-20)?  YES  NO

<input type="checkbox"/>	Specialized Care rate (for Caregivers' additional time to address BH issues)
<input type="checkbox"/>	Intensive SMHS (TBS, Crisis Stabilization, In-Home Crisis Support)
<input type="checkbox"/>	Received SMHS <b>AND</b> homeless during prior 6 mos.
<input type="checkbox"/>	2 or more psychiatric hospitalizations in the last 12 mos.
<input type="checkbox"/>	Psychiatric hospitalization and/or Discharged in the last 90 days
<input type="checkbox"/>	Living in a Short Term Residential Treatment Program (STRTP)
<input type="checkbox"/>	Probation or other Justice/Legal System
<input type="checkbox"/>	Open or Voluntary CPS/Child Welfare case

<input type="checkbox"/>	Age <b>0-5</b> w/ more than 1 MH Dx <b>OR</b> more than 1 psychotropic med
<input type="checkbox"/>	Age <b>6-11</b> w/ more than 2 MH Dx <b>OR</b> more than 2 psychotropic meds
<input type="checkbox"/>	Age <b>12-20</b> w/ more than 3 MH Dx <b>OR</b> more than 3 psychotropic meds
<input type="checkbox"/>	2 or more antipsychotic meds at same time for over 3 mos.
<input type="checkbox"/>	2 or more ER visits due to mental health in the last 6 mos.
<input type="checkbox"/>	2 or more placement changes due to behavioral health needs in the last 24 mos.
<input type="checkbox"/>	Wraparound/FSP Wrap

Other indicators where ICC may be recommended:

**Intensive Care Coordination (ICC):** ICC is a targeted case management service that facilitates communication and collaboration amongst caregivers, family members, natural supports, and multiple system providers. ICC services include assessment of, care planning for, and coordination of services, including urgent services. ICC service components include: assessing; service planning and implementation; monitoring and adapting; and transition. **Once ICC is approved, then this form will be submitted to the contract agency who will review the form and contact the provider completing this form.**

**CHOOSE ONE:** A child/youth/young adult is eligible for ICC if the answers to questions 1, 2 **AND** 3 above are all "Yes"

Client is **eligible** for ICC services and **services are recommended**

Reason for referral (include behavior issues, mental health symptoms, and change of level of care):

Client is **eligible** for ICC services and **services will not be provided** at this time

Please explain why:

Client is **NOT eligible** for ICC services (Questions 1-3 are not all "Yes")

This eligibility screening form was completed by:

Name: \_\_\_\_\_ Email/Phone: \_\_\_\_\_ / \_\_\_\_\_

Title/Program: \_\_\_\_\_ / \_\_\_\_\_ Date: \_\_\_\_\_

Supervisor signature: \_\_\_\_\_

**EMAIL or FAX completed form to:**  
Pathways to Well-Being Mental Health Program Specialist (PTW MHPS)  
[SMHS-Referrals@smcgov.org](mailto:SMHS-Referrals@smcgov.org) or (650) 341-7389

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**THIS SECTION TO BE COMPLETED BY PTW MHPS**

**APPROVED for:**

ICC                       Pathways to Well-Being                       Katie-A subclass (CFS Involvement)

Copies forwarded to:

[MIS/Billing](#)                       Contract Agency                       IPRC ([PROB\\_IPRC\\_Referrals@smcgov.org](mailto:PROB_IPRC_Referrals@smcgov.org)) w/IPRC referral form

Approved By: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_