**Intensive Behavioral Health Services (IBHS) Written Order Letter Cover Page**

**Child’s Name: Date of Birth:**

**MA ID#: Date or Written Order:**

**Parent/Guardian’s Name(s):**

**School (if applicable):**

**Other agency involvement (if applicable):**

Following my recent face-to-face appointment and/or evaluation on DATE with CHILD, and after considering less restrictive, less intrusive levels of care such as ENTER OTHER LEVELS OF CARE CONSIDERED, I am making the following Written Order.

It is medically necessary that CHILD receive a comprehensive face-to-face assessment for Intensive Behavioral Health Services (IBHS).

Along with this Written Order, I have included clinical documentation to support the medical necessity of the services ordered, including a behavioral health disorder diagnosis (listed in the most recent edition of the DSM or ICD), and measurable improvements in the identified therapeutic needs that indicate when services may be reduced, changed, or terminated, as per regulations.

**Current Behavioral Health Diagnosis:**

A behavioral health diagnosis is necessary to initiate IBHS. In addition, please include other behavioral health and/or physical health diagnoses or issues of concern, as applicable:

|  |  |
| --- | --- |
| **Behavioral Health Diagnosis (primary)** | Enter Diagnosis Here |
| Additional Behavioral Health Diagnosis | Enter Diagnosis Here (repeat row as necessary) |
| Medical conditions/physical health diagnosis  | Enter Diagnosis Here (repeat row as necessary) |

**Measurable goals and objectives to be met with IBHS:**

1. List, repeat row as necessary
2. List, repeat row as necessary

NOTE: This cover page must accompany Part A (Initial Written Order) or Part B (Written Order for Continued IBHS Treatment) to complete the Written Order.

**Part A: Initial Written Order for Initial Assessment, Stabilization and Treatment Initiation**

**A comprehensive, face-to-face assessment is recommended to be completed by an IBHS clinician to further define how the recommendations in this order will be used and to inform and complete an Individualized Treatment Plan (ITP). IBHS Treatment Services may also be delivered during the assessment period for stabilization and treatment initiation provided a treatment plan has been developed for the provision of these services.** Please select the assessment type and treatment services necessary for stabilization that you are recommending, based on the symptom(s) and/or behavior(s) of concern and the settings/domains in which they are occurring. NOTE: You must complete all sections in one row for a service to be appropriately authorized.

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| --- | --- | --- | --- |
| **Service Type** | **Assessment Type /** **Clinician type** | **Maximum number of hours per month (hpm)**NOTE: IBHS agency may provide less, as clinically indicated | **Settings in which service is necessary** |
| □ IBHS Assessment for  Individual, Group or  Evidence-based Services  NOTE: Assessment  must occur within 15  days of service initiation  | □ IBHS Clinical Assessment by a  MT, BC (may include FBA), or  Graduate Level Professional  (when MST, FFT, PCIT, CRR  HH or an IBHS Group Service) | □ Episode Start date, specify:  | □ Home□ School, specify:□ Community, specify: |
| □ IBHS-ABA Assessment for  ABA services (for ABA  Designated Providers with  an IBHS License) NOTE: Assessment  must occur within 30  days of service initiation | □ ABA Assessment by a BCBA or  BC-ABA (must include FBA  and/or Skills Assessment) | □ Episode Start date, specify: | □ Home□ School, specify:□ Community, specify: |
| □ BHRS Assessment for BHRS  Services  NOTE: Assessment  must occur within 15  days of service initiation  | □ BHRS Clinical Assessment by  an MT or BSC (may include  FBA)  | □ Episode Start date, specify: | □ Home□ School, specify:□ Community, specify: |
| □ BHRS Assessment for  ABA Services (For ABA  Designated Providers  without an IBHS License) NOTE: Assessment  must occur within 30  days of service initiation  | □ ABA Clinical Assessment by  an BSC or BCBA  (must include FBA and/or Skills  Assessment)  | □ Episode Start date, specify: | □ Home□ School, specify:□ Community, specify: |
| □ STS Assessment for School  Therapeutic Services  NOTE: Assessment  must occur within 15  days of service initiation  | □ STS Clinical Assessment by an  MT or BC | □ Episode Start date, specify: | □ Home□ School, specify:□ Community, specify: |
| □ IBHS Individual Services/  Evidence-Based BHRS  Exception Services | □ Multi-systemic Therapy (MST)□ Functional Family Therapy (FFT)□ Mobile Therapist (MT)□ Behavior Consultant (BC)□ Behavior Health Technician  (BHT)\*  \*NOTE: an FBA is required first | □ Episode□ EpisodeUp to \_\_\_ hpmUp to \_\_\_ hpmUp to \_\_\_ hpmStart date, specify: | □ Home□ School, specify:□ Community, specify: |
| □ IBHS Group Services/ BHRS  Exceptions | □ Early childhood treatment□ Social Skills treatment□ Summer Therapeutic Program  (STAP)□ Other, specify: | Up to \_\_\_ hpmUp to \_\_\_ hpmUp to \_\_\_ hpmUp to \_\_\_ hpmStart date, specify:  | □ Group service site□ If applicable, specify  setting(s) other than  the group service site:  |

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| □ IBHS ABA Services (for ABA Designated Providers with an IBHS License) | □ Behavior Analytic Services (BCBA)□ Behavior Consultant (BC-ABA)□ Assistant Behavior Consultant  (Assistant BC-ABA)□ Behavioral Health Technician  (BHT-ABA)\* \*NOTE: an FBA is required first | Up to \_\_\_ hpmUp to \_\_\_ hpmUp to \_\_\_ hpmUp to \_\_\_ hpmStart date, specify: | □ Home□ School, specify:□ Community, specify: |
| □ BHRS  | □ Mobile Therapist (MT)□ Behavior Specialist Consultant  (BSC)□ Therapeutic Support Staff- School\*□ Therapeutic Support Staff-  Non-School\* \*NOTE: an FBA is required first | Up to \_\_\_ hpmUp to \_\_\_ hpmUp to \_\_\_ hpmUp to \_\_\_ hpmStart date, specify:  | □ Home□ School, specify:□ Community, specify: |
| □ BHRS- ABA (For ABA Designated  Providers without an IBHS  License) | □ ABA-Behavior Specialist  Consultation (ABA-BSC)□ ABA-Therapeutic Support  Staff-School (ABA-TSS-S)\*□ ABA-Therapeutic Support  Staff-Non-School (ABA-TSS-NS)\* \*NOTE: an FBA is required first | Up to \_\_\_ hpmUp to \_\_\_ hpmUp to \_\_\_ hpmStart date, specify: | □ School, specify:□ Community, specify: |
| □ STS | □ STS Level 1□ STS Level 2□ STS Level 3 | Start date, specify:  | □ School, specify: |
| □ Other IBHS Treatment  | □ CRR Host Home□ Other, specify: | Start date, specify:  | □ Home□ Community, specify: |

**Collaboration and Confirmation:**

*I confirm that following my recent face-to-face appointment and/or evaluation of this child, and after considering less restrictive levels of care, as well as the prioritization of available evidence-based treatments, I am making the recommendations as per the above Written Order.*

Prescriber’s Name (please print): Degree:

License Type: NPI#: PROMISE ID#:

Prescriber’s Signature: Date:

*I confirm that I have participated in the face-to-face appointment and/or evaluation (of my child) and understand the above recommendations for further assessment and, if applicable, treatment initiation for stabilization under IBHS. I understand that the treatment hours listed above describe the maximum amount to be received per month and that IBHS treatment hours may vary, based on clinical need and ongoing assessment.*

Parent/Guardian’s Name (please print):

Parent/Guardian’s Signature: Date:

Youth’s Name (if 14 or older; please print):

Youth’s Signature (if 14 or older): Date:

***If you need to be connected to an IBHS provider in the CBH network, please contact CBH Member Services at 1-888-545-2600.***

**Part B: Written Order for Continued Treatment**

**A comprehensive, face-to-face assessment (attached) has been completed by this prescriber and/or an IBHS clinician to further define how the recommendations in this written order will be used. An Individualized Treatment Plan (attached) has also been completed, based on the result of the assessment.** Please select which one of the following service types you are recommending, based on the symptom(s) and/or behavior(s) of concern and the settings/domains in which they are occurring. NOTE: You must complete all sections in one row for service to be appropriately authorized.

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| --- | --- | --- | --- |
| **Service Type** | **Assessment Type /** **Clinician type** | **Maximum number of hours per month (hpm)**NOTE: IBHS agency may provide less, as clinically indicated | **Settings in which service is necessary** |
| □ IBHS Individual  Services/Evidence Based  BHRS Exception Services | □ Multi-systemic Therapy (MST)□ Functional Family Therapy (FFT)□ Mobile Therapist (MT)□ Behavior Consultant (BC)□ Behavior Health Technician  (BHT)\*  \*NOTE: an FBA is required first | □ Episode□ EpisodeUp to \_\_\_ hpmUp to \_\_\_ hpmUp to \_\_\_ hpmStart date, specify:  | □ Home□ School, specify:□ Community, specify: |
| □ IBHS Group Services/ BHRS Exceptions | □ Early childhood treatment□ Social Skills treatment□ Summer Therapeutic Program  (STAP)□ Other, specify: | Up to \_\_\_ hpmUp to \_\_\_ hpmUp to \_\_\_ hpmUp to \_\_\_ hpmStart date, specify:  | □ Group service site□ If applicable, specify  setting(s) other than  the group service site:  |
| □ ABA Services | □ Behavior Analytic Services (BCBA)□ Behavior Consultant (BC-ABA)□ Assistant Behavior Consultant  (Assistant BC-ABA)□ Behavioral Health Technician  (BHT-ABA)\* \*NOTE: an FBA is required first | Up to \_\_\_ hpmUp to \_\_\_ hpmUp to \_\_\_ hpmUp to \_\_\_ hpmStart date, specify:  | □ Home□ School, specify□ Community, specify: |
| □ BHRS (including ABA under  BHRS) | □ Mobile Therapist (MT)□ Behavior Consultant (BC)□ Therapeutic Support Staff-  School\*□ Therapeutic Support Staff-  Non-School\* \*NOTE: an FBA is required first | Up to \_\_\_ hpmUp to \_\_\_ hpmUp to \_\_\_ hpmUp to \_\_\_ hpmStart date, specify:  | □ Home□ School, specify:□ Community, specify: |
| □ BHRS- ABA (For ABA  Designated Providers  without an IBHS License) | □ ABA-Behavior Specialist  Consultation (ABA-BSC)□ ABA-Therapeutic Support  Staff-School (ABA-TSS-S)\*□ ABA-Therapeutic Support  Staff-Non-School (ABA-TSS-NS)\* \*NOTE: an FBA is required first | Up to \_\_\_ hpmUp to \_\_\_ hpmUp to \_\_\_ hpmStart date, specify: | □ School, specify:□ Community, specify: |

(continued on next page)

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| STS | □ STS Level 1□ STS Level 2□ STS Level 3 | Start date, specify: | □ School, specify: |
| □ Other IBHS Treatment  | □ CRR Host Home□ Other, specify: | Start date, specify:  | □ Home□ Community, specify: |

**Collaboration and Confirmation:**

*I confirm that following my recent face-to-face appointment and/or evaluation of this child, and after considering less restrictive levels of care, as well as the prioritization of available evidence-based treatments, I am making the recommendations as per the above Written Order.*

Prescriber’s Name (please print): Degree:

License Type: NPI#: PROMISE ID#:

Prescriber’s Signature: Date:

*I confirm that I have participated in the face-to-face appointment and/or evaluation (of my child) and understand the above recommendations for treatment under IBHS. I understand that treatment hours listed above describe the maximum amount to be received per month and that IBHS treatment hours may vary, based on clinical need and ongoing assessment.*

Parent/Guardian’s Name (please print):

Parent/Guardian’s Signature: Date:

Youth’s Name (if 14 or older; please print):

Youth’s Signature (if 14 or older): Date: \_\_\_

***If you need to be connected to an IBHS provider in the CBH network, please contact CBH Member Services at 1-888-545-2600.***