**Community Behavioral Health**

801 Market Street/7th Floor/Philadelphia, PA 19107

215-413-3100

**INTENSIVE BEHAVIORAL HEALTH SERVICES (IBHS)**

**FACE SHEET**

**PROVIDERS: PLEASE COMPLETE THIS FORM IN FULL AND SUBMIT WITH ALL REQUESTS**

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

**To: CBH Clinical Management – IBHS team**

**From: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Agency Contact Person**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Agency Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CBH Provider #**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Agency Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Agency Fax**

**Re: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Youth Name**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Youth MA#**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent/Legal Guardian Name**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Street Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip code**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile Phone**

**School/Placement Info:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Child’s School**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other Child Placement (e.g. daycare, after-school program)**

**PLEASE CHECK YES OR NO FOR EACH ITEM BELOW:**

**DHS INVOLVEMENT:  No  Yes If yes, name of DHS/CUA Worker:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone # of DHS/CUA Worker:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**REGISTERED WITH IDS:  No  Yes If yes, name of Supports Coord:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone # of Supports Coord:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**COURT INVOLVEMENT:  No  Yes If yes, name of PO:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone # of PO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**COMMENTS:**

**Intensive Behavioral Health Services (IBHS) Written Order**

**Cover Page**

**Child’s Name: Date of Birth:**

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

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 current 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 primary 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)** | **Required- 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
3. List, repeat row as necessary

NOTE: This cover page must accompany all submissions of 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. For Initial Transition to Regionalized IBHS, authorizations will be for 3, 5, or 7 months depending on the services the youth received in the 2019-2020 school year. If the youth is changing providers, this must be accompanied by a Progress Monitoring Form. All treatment authorizations for other services will align with program description or be for 180 days, unless otherwise specified.**

|  |  |  |  |
| --- | --- | --- | --- |
| **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** |
| **INITIAL TRANSITION TO REGIONALIZED IBHS- MUST BE SUBMITTED BY AUGUST 14, 2020** | | | |
| Regionalized IBHS – Initial  Authorization | Behavior Consultant (BC)  Mobile Therapist (MT)  Group Mobile Therapist (MT)  Behavior Health Technician  (BHT) | Up to 20 hpm  Up to 20 hpm  Up to 4 hpm  Up to 120 hpm  Start date: 08/31/2020 | Home  School, specify:  Community, specify: |
| **INITIAL IBHS ASSESSMENT AND TREATMENT SERVICES** | | | |
| IBHS Assessment for Individual,  Group or Evidence-based  Services (For providers with an  IBHS license)  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 | IBHS ABA Assessment by a BCBA  or BC-ABA (must include FBA  and/or Skills Assessment) | Episode    Start date, specify: | Home  School, specify:  Community, specify: |
| **ASSESSMENT AND TREATMENT SERVICES PROVIDED BY ABA-DESIGNATED PROVIDERS (PER CBH BULLETIN 20-03)** | | | |
| BHRS Assessment for ABA  Services (For ABA Designated  Providers without an IBHS  License)  NOTE: Assessment must occur within 30 days of service initiation | 400-130: ABA Clinical Assessment  (must include FBA and/or Skills  Assessment) and  400-131: ABA Initial Treatment-  Autism | Episode    Start date, specify: | Home  School, specify:  Community, specify: |

**PART A, page 2**

|  |  |  |  |
| --- | --- | --- | --- |
| **IBHS DIRECT TO TREATMENT SERVICES FOLLOWING AN EVALUATION (i.e. ASSESSMENT AUTH NOT NEEDED)** | | | |
| Regionalized IBHS (Individualized request) | Behavior Consultant (BC)  Mobile Therapist (MT)  Group Mobile Therapist (GMT)  Behavior Health Technician  (BHT)\*  \*NOTE: an FBA is required first | Up to \_\_\_ hpm  Up to \_\_\_ hpm  Up to \_\_\_ hpm  Up to \_\_\_ hpm  Start date, specify: | Home  School, specify:  Community, specify: |
| IBHS Evidence-Based Therapies | Functional Family Therapy (FFT)  Multi-systemic Therapy (MST)  Multi-systemic Therapy - Problem  Sexual Behavior (MST-PSB) | □ Episode  □ Episode  □ Episode  Start date, specify: | Home  School, specify:  Community, specify: |
| IBHS Group Services | IBHS Group Service  Other, specify: | Up to \_\_\_ hpm  Up to \_\_\_ hpm  Start date, specify: | Group service site  If applicable, specify  setting(s) other than  the group service site: |
| IBHS ABA Services (For ABA  Designated Providers with  an IBHS License) | Behavior Analytic Services (BCBA)  Behavior Consultation (BC-ABA)  Assistant Behavior Consultation  (Assistant BC-ABA)  Behavioral Health Technician  (BHT-ABA)\*  \*NOTE: an FBA is required first | Up to \_\_\_ hpm  Up to \_\_\_ hpm  Up to \_\_\_ hpm  Up to \_\_\_ hpm  Start date, specify: | Home  School, specify:  Community, specify: |
| **BHRS DIRECT TO TREATMENT SERVICES FOLLOWING AN EVALUATION (i.e. ASSESSMENT AUTH NOT NEEDED)** | | | |
| BHRS Exceptions (through  1/20/2021 maximum) | Early childhood treatment program  Clinical Transition & Stabilization  (CTSS-Bethanna)  Wellness & Resiliency -NCS  Summer Therapeutic Program  (STAP or STEP)  Other, specify: | □ Episode  □ Episode  □ Episode  □ Episode  Up to \_\_\_ hpm  Start date, specify: | Group service site  If applicable, specify  setting(s) other than  the group service site: |
| Other Treatment | CRR Host Home  Other, specify: | Start date, specify: | Home  Community, specify:  Other, specify: |

**PART A, page 3**

**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. I further confirm that I have communicated these recommendations for treatment to the youth, youth’s parents, and/or legal guardians in a language easily understood by all. I explained that the number of treatment hours listed above describes the* ***maximum*** *amount that can be received per month over the authorization period that begins now. Finally, I informed the youth and their parent/legal guardian that IBHS treatment hours may vary, based on increasing or decreasing clinical need, whenever changes in location of service are made (such as for summer programming or holidays), and/or the full team’s ongoing assessment of clinical need.*

Prescriber’s Name (please print): Degree:

License Type: NPI#: PROMISE ID#:

Prescriber’s Signature: 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 (Concurrent Review)**

**A comprehensive, face-to-face assessment has been completed by this prescriber and/or an IBHS clinician to define the recommendations in this written order. An Individualized Treatment Plan (ITP) has also been completed, based on the results 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 services to be appropriately authorized. If this is a request for services following 90 days or more of treatment, a Progress Review Summary is required to be ATTACHED to establish medical necessity of continued services, per CBH Bulletin 20-02.**

|  |  |  |  |
| --- | --- | --- | --- |
| **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 CONTINUED TREATMENT SERVICES** | | | |
| Regionalized IBHS | Behavior Consultant (BC)  Mobile Therapist (MT)  Group Mobile Therapist (GMT)  Behavior Health Technician  (BHT)\*  \*NOTE: an FBA is required first | Up to \_\_\_ hpm  Up to \_\_\_ hpm  Up to \_\_\_ hpm  Up to \_\_\_ hpm  Start date, specify: | Home  School, specify:  Community, specify: |
| IBHS Evidence-Based Therapies | Functional Family Therapy (FFT)  Multi-systemic Therapy (MST)  Multi-systemic Therapy - Problem  Sexual Behavior (MST-PSB) | □ Episode  □ Episode  □ Episode  Start date, specify: | Home  School, specify:  Community, specify: |
| IBHS Group Services | IBHS Group Service  Other, specify: | Up to \_\_\_ hpm  Up to \_\_\_ hpm  Start date, specify: | Group service site  If applicable, specify  setting(s) other than  the group service site: |
| IBHS ABA Services (For ABA  Designated Providers with  an IBHS License) | Behavior Analytic Services (BCBA)  Behavior Consultation (BC-ABA)  Assistant Behavior Consultation  (Assistant BC-ABA)  Behavioral Health Technician  (BHT-ABA)\*  \*NOTE: an FBA is required first | Up to \_\_\_ hpm  Up to \_\_\_ hpm  Up to \_\_\_ hpm  Up to \_\_\_ hpm  Start date, specify: | Home  School, specify:  Community, specify: |
| **CONTINUED BHRS TREATMENT SERVICES** | | | |
| BHRS Exceptions (through  1/20/2021 maximum) | Early childhood treatment program  Clinical Transition & Stabilization  (CTSS-Bethanna)  Wellness & Resiliency -NCS  Summer Therapeutic Program  (STAP or STEP)  Other, specify: | □ Episode  □ Episode  □ Episode  □ Episode  Up to \_\_\_ hpm  Start date, specify: | Group service site  If applicable, specify  setting(s) other than  the group service site: |
| Other Treatment | CRR Host Home  Other, specify: | Start date, specify: | Home  Community, specify:  Other, specify: |

**PART B, page 2**

**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. I further confirm that I have communicated these recommendations for treatment to the youth, youth’s parents, and/or legal guardians in a language easily understood by all. I explained that the number of treatment hours listed above describes the* ***maximum*** *amount that can be received per month over the authorization period that begins now. Finally, I informed the youth and their parent/legal guardian that IBHS treatment hours may vary, based on increasing or decreasing clinical need, whenever changes in location of service are made (such as for summer programming or holidays), and/or the full team’s ongoing assessment of clinical need.*

Prescriber’s Name (please print): Degree:

License Type: NPI#: PROMISE ID#:

Prescriber’s Signature: 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.***