Updated: 01/17/2021

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**

_____ **Primary Email** _____ **Secondary Email**

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:

Updated: 0/17/2021

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 Intensive Behavioral Health Services (IBHS). This Written Order includes 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 IBH 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: 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. All treatment authorizations will align with program description or be for 365 days, unless otherwise specified. Start date will be date reviewed, 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**
IBHS INITIAL ASSESSMENT AND TREATMENT SERVICES			
☐ IBHS Initial Assessment and Treatment for Individual or Group Services	☐ 425-4 (Assessment) and 425-5 (Initial Treatment)	☐ Episode – 15 days (up to 400 units) of assessment and 30 days (up to 1,500 units) of treatment Start date, specify:	☐ Home ☐ School, specify: ☐ Community, specify:
☐ IBHS-ABA Initial Assessment and Treatment for ABA Services (For ABA Designated Providers with an IBHS License)	☐ 425-6 (Assessment-ABA) and 425-7 (Initial Treatment-ABA)	☐ Episode – 30 days (up to 750 units) of assessment and 45 days (up to 2,500 units) of treatment Start date, specify:	☐ Home ☐ School, specify: ☐ Community, specify:
IBHS DIRECT TO TREATMENT SERVICES FOLLOWING AN EVALUATION (i.e. ASSESSMENT AUTH NOT NEEDED)			
☐ Regionalized IBHS (for child to be served by Regionalized provider, per school cluster)	☐ 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 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:
☐ IBHS Evidence-Based Therapies	☐ Functional Family Therapy (FFT) ☐ Multi-systemic Therapy (MST) ☐ Multi-systemic Therapy - Problem Sexual Behavior (MST-PSB)* *NOTE: a referral, psych eval and Initial ISPT are also required	☐ Episode ☐ Episode ☐ Episode Start date, specify:	☐ Home ☐ School, specify: ☐ Community, specify:

☐ IBHS Other	☐ Early Childhood Intensive Treatment program (e.g., CORE, PACT, PFI), specify: ☐ Clinical Transition & Stabilization (CTSS @ Bethanna) ☐ Summer Therapeutic Activities Program (STEP or STAP), specify: ☐ Group Mobile Therapist (GMT), specify: ☐ IBHS Group Service, specify:	☐ Episode, 180 days ☐ Episode, 90 days ☐ Episode, start date to end date Other Start date, specify:	☐ Group service site ☐ If applicable, specify setting(s) other than the group service site:

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 and an Individualized Treatment Plan (ITP) has been developed, based on the results of the assessment. The following treatment services are now ordered to implement the ITP and to help the member achieve their treatment goals. 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 a service to be appropriately authorized. All treatment authorizations will align with program description or be for 365 days, unless otherwise specified. Start date will be date reviewed, unless otherwise specified. 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
☐ Regionalized IBHS (For child to be served by Regionalized provider, per school cluster)	☐ 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 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:
☐ IBHS Evidence-Based Therapies	☐ Functional Family Therapy (FFT) ☐ Multi-systemic Therapy (MST) ☐ Multi-systemic Therapy - Problem Sexual Behavior (MST-PSB)* *NOTE: a referral, psych eval and Initial ISPT are also required	☐ Episode ☐ Episode ☐ Episode Start date, specify:	☐ Home ☐ School, specify: ☐ Community, specify:
☐ IBHS Other	☐ Early Childhood Intensive Treatment program (e.g., CORE, PACT, PFI), specify: ☐ Clinical Transition & Stabilization (CTSS @ Bethanna) ☐ Summer Therapeutic Activities Program (STEP or STAP), specify: ☐ Group Mobile Therapist (GMT), specify: ☐ IBHS Group Service, specify:	☐ Episode, 180 days ☐ Episode, 90 days ☐ Episode, start date to end date Other Start date, specify:	☐ Group service site ☐ If applicable, specify setting(s) other than the group service site:

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.