INTENSIVE BEHAVIORAL HEALTH SERVICES (IBHS) WRITTEN ORDER

Providers Must Complete All Fields Prior to CBH Submission.

Date		To: CBH Clinical Management – IBHS Team	
From:			
Your Name		Your Email	
Agency Name		CBH Provider #	
Agency Phone		Agency Fax	
Regarding:			
Youth Name		Parent/Legal Guardian	
Street Address		ZIP Code	
Home Phone		Mobile Phone	
Primary Email		Other Email	
School/Placement Information:			
Child's School (Necessary to identify IBHS regionalized provider)			
Other Child Placement (e.g., Daycare, Pre-K)			

Please Check Yes or No For Each Item Below.

DHS Involvement?	☐ Yes	☐ No	*If yes,*		
DHS/CUA Worker Name				DHS/CUA Worker Phone	
Registered With IDS?	☐ Yes	☐ No	*If yes,*		
Supports Coordinator Name				Supports Coordinator Phone	
Court Involvement?	☐ Yes	☐ No	*If yes,*		
PO Name				PO Phone	
TPL Plan Other Than CBH?	☐ Yes	☐ No			

IF YES, STOP HERE and seek primary authorization or denial through all other payors before submitting to CBH. CBH cannot review any request for IBHS unless CBH is the primary funder.

Is this a request for your agency to staff?	☐ Yes	☐ No	*If no, why not? (e.g., not in cluster, agency doesn't offer ABA)*	
Reason				

Child's Name		Date of Birth	
MA ID# (10 Digits)		Written Order Date	

Following my recent face-to-face appointment and/or evaluation on **[DATE, within last 365 days]** with **[CHILD'S NAME]**, and after considering less restrictive, less intrusive levels of care (LOC) such as **[OTHER LOCs CONSIDERED]**, I am making the following Written Order.

It is medically necessary that **[CHILD'S NAME]** receive Intensive Behavioral Health Services (IBHS). This Written Order includes a current, primary 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 IBHS may be reduced, changed, or terminated, as per regulations.

Additionally, a comprehensive, face-to-face assessment must be completed by an IBHS clinician to further define how the recommendations in this order will be used to inform and complete an Individualized Treatment Plan (ITP). Limited treatment services by qualified staff may also be delivered during the initial assessment period, provided a treatment plan has been developed for the provision of these services.

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:

Primary Behavioral Health Diagnosis *(ICD-9/10 or DSM-5 code and full name with severity specifiers as required)*:	
Additional Behavioral Health Diagnoses:	
Medical Conditions/Physical Health Diagnoses:	

Measurable Goals and Objectives to be Met With IBHS

and which justify the medical necessity of the types and amounts of services prescribed in this Written Order:

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Please select the services that you are recommending based on the symptoms/behaviors of concern and the setting(s) in which services may occur. You must complete all sections in one or two rows for a service to be appropriately authorized. **All treatment authorizations will align with the proposed ITP and be issued in compliance with CBH Bulletins, or as indicated by the program service description (e.g., CTSS is 90 days). Start date will be the date reviewed unless otherwise specified.**

Service Type	Assessment/Clinician Type	Maximum # of Hours Per Month (HPM) *NOTE: IBHS agency may provide less, as clinically indicated*	Settings in Which Service is Prescribed
IBHS Initial Assessment and Treatment Services – Requires WO Only			
☐ IBHS Initial Assessment and Treatment for Individual or Group Services	☐ 425-4 (Assessment) and 425-5 (Initial Treatment) ☐ Family Peer Support ☐ Care Coordinator	☐ Episode – 15 days (up to 60 units) assessment and 30 days (up to 100 units) treatment Specify Start Date: _____	☐ Home ☐ School, specify: _____ ☐ Community, specify: _____
☐ IBHS-ABA Initial Assessment and Treatment for ABA Services	☐ 425-6 (Assessment-ABA) and 425-7 (Initial Treatment-ABA)	☐ Episode – 30 days (up to 100 units) assessment and 45 days (up to 200 units) treatment Specify Start Date: _____	☐ Home ☐ School, specify: _____ ☐ Community, specify: _____
IBHS Individual or Group Services – Requires WO, Assessment, and ITP w/Scheduler			
☐ IBHS Individual Services (Child to be served by regionalized IBHS provider, per school cluster)	☐ Behavior Consultant (BC) ☐ Mobile Therapist (MT) ☐ Behavior Health Technician (BHT) *NOTE: an FBA is required first* ☐ Family Peer Support ☐ Care Coordinator	BC: Up to _____ hpm MT: Up to _____ hpm BHT: Up to _____ hpm Specify Start Date: _____	☐ Home ☐ School, specify: _____ ☐ Community, specify: _____
☐ IBHS Group Services *NOTE: Members may receive group in addition to individual services (row above)*	☐ Group Mobile Therapist (GMT)	GMT: Up to _____ hpm Specify Start Date: _____	☐ School, specify: _____ ☐ Community, specify: _____
IBHS Applied Behavior Analysis (ABA) Services – Requires WO, Assessment, and ITP w/Scheduler			
☐ IBHS ABA Individual Services	☐ Behavior Analytic Services (BCBA) ☐ Behavior Consultation (BC-ABA) ☐ Assistant Behavior Consultation (Assistant BC-ABA)	BCBA: Up to _____ hpm BC-ABA: Up to _____ hpm Assistant BC-ABA: Up to _____ hpm	☐ Home ☐ School, specify: _____ ☐ Community, specify: _____

Service Type	Assessment/Clinician Type	Maximum # of Hours Per Month (HPM) *NOTE: IBHS agency may provide less, as clinically indicated*	Settings in Which Service is Prescribed
	☐ Behavioral Health Technician (BHT-ABA) *NOTE: an FBA is required first*	BHT-ABA: Up to _____ hpm Specify Start Date: _____	
☐ IBHS ABA Group Services *NOTE: Members may receive group in addition to individual Services (row above)*	☐ Group ABA Services	Up to _____ hpm Specify Start Date: _____	☐ School, specify: _____ ☐ Community, specify: _____
☐ ABA Individual or Group Services in a Center *NEW*	☐ ABA 1:1 in a center by BHT-ABA ☐ ABA 1:1 in a center by BC-ABA ☐ ABA Group BHT-ABA in a center ☐ ABA Group BC-ABA in a center	1:1 BHT-ABA: Up to _____ hpm 1:1 BC-ABA: Up to _____ hpm Group BHT-ABA: Up to _____ hpm Group BC-ABA: Up to _____ hpm ☐ Episode, 90 Days Specify Start Date: _____	☐ Center-based location, specify provider and site address: _____
IBHS Evidence-Based and Specialized Programs			
☐ ABA Early Childhood Intensive Services *NEW NOTE: ABA-EC are stand-alone comprehensive programs for children with ASD, ages 3-5, and cannot co-occur with any other IBHS*	☐ ABA Early Childhood Intensive Services	☐ Episode, 90 Days Specify Start Date: _____	☐ Center-based location, specify provider and site address: _____
☐ 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 (FFT) ☐ Episode (MST) ☐ Episode (MST-PSB) Specify Start Date: _____	☐ Home ☐ School, specify: _____ ☐ Community, specify: _____

Service Type	Assessment/Clinician Type	Maximum # of Hours Per Month (HPM) *NOTE: IBHS agency may provide less, as clinically indicated*	Settings in Which Service is Prescribed
☐ IBHS Other – Clinical Transition and Stabilization (CTSS)	☐ CTSS (CTSS @Bethanna)	☐ Episode, 90 Days, up to 40/160 hpm	☐ All environments where stabilization is needed, including home, school, and community

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.

Print Prescriber's Name: _____ Degree: _____

License Type: _____ NPI#: _____ PROMISe ID#: _____

Authorized Signature: _____ Date: _____

Print Name and Title: _____

Please Note: *ALL fields above required. Failure to submit a complete form may result in CBH marking this request as insufficient and/or denying the request.*

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