SUPPLEMENTAL INTENSIVE HOME BASED SERVICES ASSESSMENT

MH 744
Revised 4/28/21

I. Client Identifying Information

Name: _____ DOB: _____ Age: _____ Sex: ☐ Male ☐ Female
Ethnicity: _____
Current Living Situation: _____

Parent/Caregiver: _____ Address: _____ Phone: _____

Other Systems Currently Involved in: ☐ DCFS ☐ Special Education ☐ Probation ☐ Other _____

II. IHBS Eligibility

Requested start date for IHBS Services: _____
LACDMH will make a determination to approve or deny the request within five (5) business days from receipt.

☐ Expedited request needed: standard 5 business day timeframe could seriously jeopardize the client's life or health or ability to attain, maintain, or regain maximum functioning.

Date of most recent or upcoming CFT Meeting: _____

III. Target Population

The following are indicators of the need for IHBS. These indicators are not requirements but serve as guidance in order to identify children/youth who may need or benefit from IHBS.

Client is receiving, or being considered for one of the following:

- ☐ Wraparound
- ☐ IFCCS
- ☐ FSP
- ☐ TBS
- ☐ ISFC
- ☐ Crisis Stabilization
- ☐ Crisis Intervention
- ☐ High-level-care institutional settings (Group Homes or Short-Term Residential Therapeutic Programs (STRTPs))
- ☐ Other: _____

☐ Client has been discharged within 90 days from, or currently reside in, or are being considered for placement in, a psychiatric hospital or 24-hour mental health treatment facility
☐ Client has experienced two or more mental health hospitalizations in the last 12 months
☐ Client has experienced at least one placement change due to behavioral health needs
☐ Client has been treated with two or more antipsychotic medications, at the same time, over a three-month period
☐ Client has two or more emergency room visits in the last 6 months due to primary mental health condition or need
☐ Client has been detained, pursuant to W&I sections 601 and 602, primarily due to mental health needs
☐ Client has received SMHS within the last year, and have been reported homeless within the prior six months

For 0-5 years old:
- ☐ More than one psychotropic medication
- ☐ More than one mental health diagnosis

For 6-11 years old:
- ☐ More than two psychotropic medications
- ☐ More than two mental health diagnoses

For 12-17 years old:
- ☐ More than three psychotropic medications
- ☐ More than three mental health diagnoses

☐ Other circumstances. Please specify: _____

Name: **DMH ID#:**

Agency: **Provider #:**

Los Angeles County – Department of Mental Health

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IV. IHBS Assessment	
1. Identify the behaviors and/or symptoms that indicate the need for intensive services in home or in the community:	
Be sure to include: *Intensity* *Frequency* *Duration* *Where Occurring* *When Occurring*	
2. (Optional) Provide any additional clinical information supporting the need for IHBS: .	

V. Referring Provider Contact Information

Contact Name: _____ Contact Email: _____ Contact Phone Number: _____

Signatures

_____	_____	_____	_____
Signature & Discipline	Date	Co-Signature & Discipline (if required)	Date

Name: **DMH ID#:**

Agency: **Provider #:**

Los Angeles County – Department of Mental Health