1211 - INTENSIVE HOME BASED SERVICES (IHBS) ASSESSMENT

IHBS are individualized and strength-based **Mental Health Rehabilitation/Intervention Activities** designed to ameliorate mental health conditions that interfere with successful functioning by:

- Improving the child/youth's ability to function successfully in their surroundings.
- Improving the family/caregiver's ability to help the child/youth function successfully in their surroundings.

I.

A) Identify the Behavior(s) and/or Skills Deficit(s) that reduces the child/youth's ability to function successfully in the home, school, and/or community (**if Skills Deficit, skip to G**):

B) History of the behavior(s):

C) Situational factors (what's going on before the behavior?)**:**

D) Consequences of behavior (what happens during and after the behavior?)**:**

E) Meaning of behavior (what does the child expect to achieve?)**:**

1211–IHBS ASSESSMENT *Completed by C&FS Clinician with the initial IHBS Authorization request for clients and updated at reauthorization or as needed.*	**C&FS Provider Information** Name: Title: Agency: Phone:	**Client Information** Name: Client ID: DOB:

F) Interventions used in the past (identify if successful or not):

G) Replacement behavior(s) and/or functional skill(s) desired (what behaviors or skills will help the child/youth achieve the goals/objectives of their plan?)**:**

_____ _____

LPHA Clinician Signature/Title **Date**

Section I to be completed by BH Clinician.

II.

Sources of Information:

☐ **Review** of most recent BH assessment and other current records

☐ **Current clinical relationship or interview** of the parents, caregivers, teachers, other service providers, and supporters

☐ **Current clinical relationship or interview** of the child/youth

☐ **Observation** of the child/youth in key settings (check all that apply): ☐ home ☐ school ☐ community

CHILD & FAMILY TEAM MEETING RECOMMENDING IHBS: CHILD ☐ **Yes** ☐ **No** **Date:** _____

& FAMILY TEAM MEMBERS RECOMMENDING IHBS: ☐ **Yes** ☐ **No** **Date:** _____

_____ _____

LPHA Clinician Signature/Title **Date**

_____ _____

LPHA Supervisor Signature/Title (if required) **Date**

Section II to be completed by BH Clinician and Supervisor after review of section I.

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III.

Child/youth can benefit from & meets medical necessity requirement for IHBS: ☐ **Yes** ☐ **No**

If *No,* please explain:_____

_____ _____

LPHA Sr. MH Program Manager/Title/Designee Signature **Date**

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