INTENSIVE BEHAVIORAL HEALTH RESOURCES TASK (IBHRT) CONSULTATION FORM

DEMOGRAPHICS

Application Date: _____

Youth's Name:			*Date of Birth:*	
State of Birth:			*Age:*	
Assigned Gender at birth: *Gender Identity:*			*Adopted:* *Adopted via Child Welfare Agency:*	☐ Yes ☐ No State _____ ☐ Yes ☐ No
Height: *Weight:*			*Ethnicity:* *Tribal Affiliation / Enrollment:* *If yes, which Tribe(s)?*	☐ Yes ☐ No
Parent / Legal Guardian's Name: *Address:*			*Parent / Legal Guardian's Phone:* *Email:*	
School District: *School Name:*			*IEP or 504 plan:*	☐ Yes ☐ No
DDA Enrolled: *DDA Application Pending:*	☐ Yes ☐ No ☐ Yes ☐ No As of date: _____		*DDA Case Worker:* *Email:* *Phone:*	
Medicaid: *Managed Care Agency:* *Provider One Client ID#:*	☐ Yes ☐ No		*Private Insurance:* *Private Insurance Provider:*	☐ Yes ☐ No
Does youth have an open DCYF Child Welfare case? *Worker's Name:*	☐ Yes ☐ No		*Office location:* *Case Worker Phone:* *Case Worker Email:*	

Please Note: When a parent/legal guardian requests a CLIP screening, the ASO/MCO provides them with the Intensive Behavioral Health Resources Task (IBHRT) Consultation Form to fill out. The clock for the process begins once the filled-out form is returned by the parent/legal guardian. Within 3 days of receiving the completed form, the ASO/MCO will notify the parent/legal guardian that they have all necessary information to schedule the task force review. The review needs to be scheduled within 30 days.
(Per Apple Health-Integrated Managed Care (IMC) contract section 14.14.7.1)

INTENSIVE BEHAVIORAL HEALTH RESOURCES TASK (IBHRT) CONSULTATION FORM

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PSYCHIATRIC SERVICES

Diagnoses:	
Current Behavioral Health Medications:	
Name of Treating Psychiatrist or current prescriber:	

Was a psychiatric evaluation completed within the past six months? ☐ No ☐ Yes

To answer YES, the evaluation must meet the following criteria:

- *Completed and signed by a psychiatrist or a psychiatric ARNP (PhD is not sufficient). This can be done either through an inpatient or outpatient treatment provider.*
- *Includes 1 or more DSM-V diagnostic classifications.*
- *Includes at a minimum a Mental Status Exam, and a complete assessment of the youth's treatment needs.*
- *If a copy is not submitted with this consultation form, the consultation team may not consider a recommendation for CLIP.*

If NO, you do not have a psychiatric evaluation completed within the last 6 months, then do you have a psychiatric evaluation scheduled?

☐ No
☐ Yes, on date _____ with provider _____

YOUTH TREATMENT HISTORY

Psychiatric Hospitalizations:
(Please list in reverse chronological order, with the most recent hospitalization first)

Facility	*Admit Date*	*Discharge Date*

Use boxes below to enter information for 'other' or out of state hospitals		

Substance Use Disorder (SUD) Treatment Episodes

Agency	*Admit / Intake Date*	*Discharge / Termination Date*

Outpatient Mental Health Treatment Episodes (i.e. therapy, crisis services, psychiatric care, WISe)

Type of Service	*Agency*	*Services Started*	*Services Ended*

Dept of Children, Youth and Families (DCYF) Child Welfare involvement within the last two years.
(Please use "other" section if you have duplicate services.)

Service	*Agency (if applicable)*	*Admit / Intake Date*	*Discharge / Termination Date*
Foster Care (including relative placement or foster home, not Behavior Rehabilitation Services) ☐ *Yes* ☐ *No*			
Behavior Rehabilitation Services (BRS) ☐ *Yes* ☐ *No*			
Other Types of Residential Care			

☐ *Yes* ☐ *No*			
Family Preservation Services ☐ *Yes* ☐ *No*			
Family Reconciliation Services ☐ *Yes* ☐ *No*			
Other In-Home Services ☐ *Yes* ☐ *No*			
Other ☐ *Yes* ☐ *No*			
Other ☐ *Yes* ☐ *No*			

Youth & Family Team Members

How frequently does the team meet? _____

Name	*Relationship / Affiliation*	*Phone Number*	*Email Address*

NARRATIVE SECTION

1. *Please describe the strengths & interests:*
   Child / Youth:

   Family:

2. *What are the challenges and/or behaviors the youth is experiencing that have led to their need for intensive psychiatric services and treatment?*

3. *Describe what more intensive services have been tried in order to serve the youth in their community:*

4. *Family and Cultural History Narrative:*
   Please provide a brief narrative describing the youth's family and cultural history; or reference the specific document(s) which provides this information. Information should describe:
   - *Name, occupation, marital status and location of natural and/or step-parents, adoptive parents or guardians*
   - *Names and birth dates of siblings*
   - *Cultural background, including any specific practices of the youth and family*
   - *Child's current living situation*
   - *History of known psychiatric problems in the family*

5. *Developmental History Narrative:*
   Please provide a brief narrative describing the youth's developmental, intellectual and functional skill levels; or reference the specific document(s) which provides this information. Information should describe:
   - *Pregnancy, birth, developmental milestones*
   - *Identified intellectual/developmental disabilities*
   - *Is there additional assistance needed to complete age-appropriate activities of daily living?*

6. *Educational History Narrative:*
   Please provide a brief narrative describing the youth's educational history including most recent school attended, whether currently attending, current performance in school and a brief outline of youth's historical performance, and highest grade completed. (or reference to the specific document(s) which provides this information)

7. *Medical Status Narrative:*
   Any current or chronic conditions that require medication or other treatment (e.g. Diabetes, asthma, feeding/eating concerns, allergies, seizures, other health conditions)? Any major past medical incidents?

8. *Legal Status Narrative:*
   Please provide a brief narrative describing the youth's current legal status including a description of current probationary or parole status, history of diversion, adjudication and incarceration, and a description of pending charges. (or reference to the specific document(s) which provides this information)

HELP GUIDE

The following suggestions are made as you go through the pages of the screening form:

Demographics:

1. Medicaid/PIC#: The number of the client is now known as the “Provider One” number or “Client Number” and is 8 digits followed by the letters WA.

2. Private Insurance: We are asking for other private health insurance that may be in effect for the child.

3. Telephone: Please also add an EMAIL address if you have one. Staff are required to respect confidentiality if they send client information by email, and/or use an encrypted email system, but are able to discuss some arrangements by email. This speeds up communication.

4. Parents, please do not write in the shaded area.

Youth & Family Team Members:

1. Please include people currently (past 6 months) actively involved in helping the youth, If they will still be available to participate, please indicate with a check mark or *.

2. Please include family members, (even if reluctant or currently estranged), community members and community providers.

3. If some of these members have been meeting regularly as a team to address the youth’s needs, please indicate how often the team meets.

Narrative Section:

1. Q1 on Strengths: Listing these for the youth and family helps us use youth and family strengths to more quickly help all make progress.

2. Q3 on What more intensive services have been tried? - We are interested in which services listed on previous pages have been helpful, what was not helpful, and why (brief).