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Updated: 01/17/2021

Community Behavioral Health

801 Market Street/7th Floor/Philadelphia, PA 19107 215-413-3100

$\frac{\textbf{INTENSIVE BEHAVIORAL HEALTH SERVICES (IBHS)}}{\textbf{FACE SHEET}}$

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com: PROVIDER NA			
	Agency Name		CBH Provider #
	Agency Phone	a number of the second of the	Agency Fax
	Youth Name	outh D	UB:
And the second s	Youth MA#		
	Parent/Legal Guardian I	Name	
	Street Address		
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	Child's School Other Child Placement (e.g. daycare, after-sc	hool program)
LEASE CHECK YES OR NO FOR EACH IT	FEM BELOW:		
HS INVOLVEMENT: □ No □ Yes	If yes, name of DHS	S/CUA Worker:	
	Phone # of DHS/CU	JA Worker:	
EGISTERED WITH IDS: \(\simega \) No \(\simega \) Yes	If yes, name of Sup	ports Coord:	
	Dhana # of Cunnari	ts Coord:	
	rnone # of Support		
COURT INVOLVEMENT: No Yes			

COMMENTS:

Intensive Behavioral Health Services (IBHS) Written Order

Cover Page

Child's Name: _____ Date of Birth: _____

EDIT THIS FOR YOUR PATIENT FORIOUS PATIENT FOR JOUR PATIE	MA ID#:		Date	of Written C)rder:	
Following my recent face-to-face appointment and/or evaluation on DATE with CHILD, and after consideres restrictive, less intrusive levels of care such as ENTER OTHER LEVELS OF CARE CONSIDERED, I am make the following Written Order. Conange This to "INMATIENT" OR Conange This to "INMATIENT" OR Conange This to "INMATIENT" OR Consider to pt name the following Written Order. Conange This to "INMATIENT" OR Conange This to "Inmatient Diagnosis" in the most recent edition of the DSM or IC and measurable improvements in the identified therapeutic needs that indicate when IBH Services may 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 behave the latent and/or physical health diagnosis or issues of concern, as applicable: Behavioral Health Diagnosis (primary) Additional Behavioral Health Diagnosis (primary) Required Enter Diagnosis Here Enter Diagnosis Here Enter Diagnosis Here Enter Diagnosis Here (repeat row as necessary) ANTISM ANYIETY SPEETH DELAY, ABBA 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 3. List, repeat row as necessary 4. Communic - Stateges 1. Communic - Stateges 1. A bility to Magnetic to Magneti	EDIT	THIS	FOR	Your	patient	•
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NOTE: This cover page must accompany all submissions of Part A (Initial Written Order) or Part B (Writter	I same ase peens ce fix indepen	dence	7	Jaily 1	routines.	
Order for Continued (BHS Treatment) to complete the Written Order.	MOTE. This cover hage must accompar	iy ali sabiiilss	310113 01 1 6	arch (maisign sa	ritten Order) or Pa	art B (Written

Part A: Written Order for Initial Assessment, Stabilization, and Treatment Initiation

A comprehensive, face-to-face assessment <u>is recommended</u> 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 TREAT	MENT 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 TREATM	ENT SERVICES FOLLOWING AN EVALUATI	ON (I.e. ASSESSMENT AUT)	I 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 □ Functional Family Therapy (FFT) □ Multi-systemic Therapy (MST) 	Up to hpm Up to hpm Up to hpm Up to hpm Start date, specify: □ Episode □ Episode □ Episode	Home School, specify: Community, specify: Letern ination Home School, specify:
	☐ Multi-systemic Therapy - Problem Sexual Behavior (MST-PSB)* *NOTE: a referral, psych eval and Initial ISPT are also required	Start date, specify:	☐ Community, specify:

pick or un

Updated: 01/17/2021 ☐ Episode, 180 days ☐ Group service site ☐ IBHS Other ☐ Early Childhood Intensive ☐ If applicable, specify Treatment program (e.g., CORE, setting(s) other than PACT, PFI), specify: ☐ Episode, 90 days the group service site: ☐ Clinical Transition & Stabilization (CTSS @ Bethanna) ☐ Summer Therapeutic Activities ☐ Episode, start date to Program (STEP or STAP), specify: end date ☐ Group Mobile Therapist (GMT), specify: Other Start date, specify: ☐ IBHS Group Service, specify:

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:	
		Clinic Admin Usvally Has This #	

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.