Intensive In-Home Behavioral Health Treatment

IIBHT

Morrow-Wheeler-Gilliam-Grant~Umatilla

IIBHT Referral

Date: _____

Name of Youth: _____ DOB: _____

Address:_ _____

_____

Phone Number: _____

Diagnosis:

_____ _____

Legal Guardian(s): _____

Phone number(s):

_____ _____ _____

Who Referred:

_____

Is the participation agreement signed: yes _____ no ____

Description of behaviors and concerns that prompted the referral:

Send Referral to Nickie Boudreaux nickie.boudreaux@ccsemail.org **and** marissa.albat@ccsemail.org

Intensive In-Home Behavioral Health Treatment
IIBHT
Morrow-Wheeler-Gilliam-Grant~Umatilla

IIBHT Participation Agreement

Youth Name:	Prime #	County

Intensive In-Home Behavioral Health Treatment (IIBHT) is an Oregon Health Plan (OHP) level of care for youth and families. This agreement represents an understanding between Community Counseling Solutions and the identified youth and their family of the commitment to participate in IIBHT treatment plan driven strategies.

IIBHT offers many treatment services. These can be found in the youth and family's Service Plan. The Crisis and Safety Plan includes support and 24/7 crisis response. The youth and family will work with the provider. They will decide the amount and types of services that best meet the needs of the family. Providers must offer at least 4 hours of planned, in person services per week.

What youth and families can expect from the IIBHT Community Counseling Solutions staff:

- Psychiatry services: including assessment and medication management
- Individual therapy.
- Family therapy.
- Peer-delivered services.
- Skills training.
- Care coordination.

IIBHT providers then meet monthly with the youth and family. They review progress and update goals and plans.

What the IIBHT team expects from the Family: Participants understand that:

Willingness to work closely with the IIBHT team to define goals

Active participation as a member of the IIBHT team: A minimum of 4 hours per week in home treatment, monthly IIBHT team meeting, actively working toward treatment goals. IIBHT is initially a 2 month program that is reassessed monthly after the initial two month period.

Participation in IIBHT is voluntary.

_____ (Initial) I understand and agree to the commitment of IIBHT (OR)

_____ (Initial) I have been oriented to IIBHT as well as participant.

I understand this is a voluntary process, and at this time I do not wish to participate in IIBHT.

_____ _____

Youth Signature: Date

_____ _____

Parent/Guardian Signature: Date