**INTENSIVE BEHAVIORAL HEALTH SERVICES(IBHS)**

**SERVICE DESCRIPTION REVIEW CHECKLIST**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Provider: |  | | | | Region | Counties Served: | |  |
| License / Approval #: | | | |  | | | | |
| Clinical Director: | |  | | | | | | |
| Administrative Director: | | | | | | | | |
| OMHSAS Staff Reviewing: | | |  | | | Date: |  | |

**Services (check all that apply):**

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|  | 1) Individual Services |
|  | 2) Group |
|  | 3) ABA |
|  | 4) EBT delivered through individual services, ABA services or group services |

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| Comments: |
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**Service Description (5240.5)** As part of the initial licensing application, the IBHS agency shall submit to the Department for review and approval a written description of services to be provided that includes the following:

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| --- | --- | --- | --- |
|  | **Requirement** | **Met Y / N** | **Comments** |
| **1** | Identification and description of each service offered by the IBHS agency |  |  |
| **2** | Identification of the target population served by each service, including age range and presenting issues, which may include specific diagnoses |  |  |
| **3** | The days and hours each service is available |  |  |
| **4** | Identification of the counties where the IBHS agency provides each service |  |  |
| **5** | Description of admission criteria |  |  |
| **6** | Description of discharge criteria |  |  |
| **7** | Description of exclusionary criteria |  |  |
| **8** | Staffing ratios for each service offered by the IBHS agency |  |  |
| **9** | Treatment modalities |  |  |
| **10** | Locations where services are offered |  |  |
| **11** | Maximum number of children, youth or young adults who will be served at the same time through group services at a community setting or a community like setting |  |  |

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| **Notes:** |
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| **Surveyor**  **Signature:** |  | **Date:** |  |