Therapeutic Behavioral Services (TBS) Referral and Authorization

NAME / MRN

____
Primary Service Provider (Point Person), License

____
Referring Agency

____
Job Title

__________ Facility ID

__________ Program ID

The referral packet must include a copy of the following documents:

- ❒ Most recent assessment and level-of-care determination, dated/completed within the last 12 months.
- ❒ Child and Adolescent Needs and Strengths (CANS), dated/completed within last 6 months.
- ❒ Problem List
- ❒ Targeted case management (TCM) note, if applicable
- ❒ Child & Family Team (CFT) Meeting Action Plan – Client Plan of Care, if applicable.

Child being referred must meet all of the following criteria:

- ❒ Child/youth has full-scope Contra Costa (07) Medi-Cal eligibility.
- ❒ Child/youth meets medical necessity criteria.
- ❒ Child/youth is receiving other specialty mental health services.
- ❒ Child/youth is under the age of 21 years.

Certified Class Membership Eligibility - child/youth must meet one of the following criteria:

- ❒ Child/youth is placed in a short-term residential therapeutic program (STRTP) and/or locked treatment facility for the treatment of mental health needs.
- ❒ Child/youth is being considered by the County for placement in and STRTP and/or a locked treatment facility for the treatment of mental health needs.
- ❒ Child/youth has undergone at least one emergency psychiatric hospitalization related to his/her current presenting disability within the preceding 24 months.
- ❒ Child/youth is at risk of psychiatric hospitalization.
- ❒ Child/youth has previously received TBS services while a member of the class.

Clinical Need Criteria: In the clinical judgment of the mental health provider, without the additional short-term support of TBS it is highly likely that: ***(must check at least one)***

- ❒ The child/youth will need to be placed out-of-home, or into a higher level of residential care, including acute care because of the child/youth's behaviors or symptoms which jeopardize continued placement in the current facility.
- ❒ The child/youth will need TBS additional support to transition to a home or foster home or a lower level of residential placement.

Is client involved with CFS? Yes ☐ No ☐ County of Jurisdiction ____________________________

Send this form with the referral packet via secure email to TBS@cchealth.org

For questions regarding TBS referrals, contact the TBS Coordinator at:
Phone: (925) 521-5742 ● Fax: (925) 646-5810
or email: TBS@cchealth.org

NAME / MRN

Gender: ☐ Male ☐ Female ☐ Transgender ☐ Non-binary ☐ Other___________________________

____
Child's Ethnicity

___________________________	___________________________	___________________________
Current Address	City	Zip Code
Child's School	Date of Birth	Social Security Number (SSN)
Parent/Caregiver (legal responsible party)	Phone Number	Relationship to child
Parent/Caregiver (legal responsible party)	Phone Number	Relationship to child

Describe very specifically and concretely the target behavior(s) that: 1) put current living situation at risk and/or 2) put transition to a lower-level placement at risk, and/or 3) behaviors which put the child/youth at risk for possible psychiatric hospitalization.

Does your child/youth or child's caregiver have specific requests or needs with regard to the TBS Coach/ Specialist's language, culture, age, or gender?

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TBS is never a primary therapeutic intervention. TBS is always used in conjunction with other specialty mental health services such as individual therapy, family therapy, and/or Wraparound Services.

Please provide the names of staff, agency name and their phone numbers who may be involved in the child/youth's treatment. This will allow the TBS Specialist/Coach to work collaboratively with members of the treatment team.

Member	Name/Agency (County for CFS social worker)	Contact number
Psychotherapist:		
Psychiatrist:		
Probation Officer:		
Case Manager:		
Wraparound Facilitator:		
Family Partner:		
Intensive Care Coordinator:		
Intensive Home-Based Services:		
Residential/ Placement Contact:		
Children & Family Services (CFS) Social Worker:		
Other Person/Service (include role):		
Other Person/Service (include role):		

Signature of Primary Clinician (Point Person) | License/Designation/Job Title | Date

Email Address | Fax Number | Additional Contact Number

Signature of Clinician's Supervisor (if not licensed) | License/Designation/Job Title | Date

Signature of Parent/caregiver – Agreement to Participate | Relationship to child | Date

NAME / MRN

TBS REFERRAL AND AUTHORIZATION
TBS PROGRAM USE ONLY

❒ Medi-Cal verified by: __________
Initials

Reviewed and approved by: ______________________________ ________________
TBS Team Coordinator Date Approved

______________________________ ________________
Agency Assigned Date Assigned