



Behavioral Wellness

Therapeutic Behavioral Services (TBS)

**Please type, fill out completely, attach release of information (ROI),
and Medi-Cal eligibility
Submit all documents to:
bwellqcm@sbcbswell.org**

Referring Party Information:

Date of Referral:
Mental Health Provider's Name:
Phone Number:

Client Information:

Client Name:
Client ID:
DOB:
Preferred Language:

TBS:

Initial Request:
Reauthorization:

Required Criteria

Child/Youth is under the age of 21;
Child/Youth is eligible for full scope Medi-Cal; and
Child/Youth meets medical necessity criteria for Specialty Mental health Services.
AND meets ONE of the following class criteria: <i>(Check all that apply)</i>
Child/Youth is placed in a group home facility of RCL 12 or above group home and/or locked treatment facility.
Child/Youth is being considered by the county for placement in a facility described above at risk of being placed in an RCL 12 or above group home. <i>(Note documentation must reflect symptoms/behaviors leading to placing the child/youth at risk for placement in higher level of care.)</i>

Child/Youth has undergone at least one emergency psychiatric hospitalization related to his/her current presenting mental health diagnosis within the preceding 24 months. Date(s) of hospitalization:
Child/Youth has previously received TBS while a member of the certified class. Date(s):
Child/Youth is at risk of psychiatric hospitalization. <i>(Note documentation must reflect symptoms/behaviors leading to placing the child/youth at risk for placement in higher level of care.)</i>

Service Need:

It is highly likely in my clinical judgment that without the additional short-term support of therapeutic behavioral services this child/youth:
Will need to be placed out of home or in a higher level of residential care, including acute care, because of the change in the child/youth's behavior(s) or symptom(s) which jeopardize placement.
Needs this additional support to transition to a lower level of residential placement. Although the child/youth may be stable in the current placement a change in behavior(s) or symptom(s) is expected and TBS are needed to stabilize the child in the new environment.
None of the above applies <i>(Not eligible for TBS)</i>
Describe <u>very specifically and concretely</u> the behavior(s) that either put current living situation at risk, put transition to a lower level living situation at risk, or behaviors which put client at risk for psychiatric hospitalization:
What services and interventions have been or are currently being provided to address this behavior(s):
Significant history or area of need affecting behavior(s): <i>(Check all that apply, comments)</i>
Previous treatment/Placement:
Family/Social:
Abuse History:
Substance Abuse:
Current Medication:

Side effects of medication:
Medical Problems:
School/IEP:
Developmental Functioning/IQ:
Provide child/youth's Clinical Assessment #:
Provide child/youth's Treatment Plan#:
ROI attached with referral form: Yes No
Medi-Cal eligibility attached with referral form: Yes No

Mental Health Provider:

If this child/youth is authorized for TBS I agree to collaborate with TBS provider, which will include regular phone contact. I will write TBS into my treatment plan as an intervention.	
Name of mental health provider:	Date:
Name of supervisor:	Date:

This Section to be Completed by Regional Manager	
Approved:	Yes No
If no, provide reason denied:	
Amount of days/months approved for:	
Start Date:	End Date:
Approved by (Regional Manager):	Date: