Santa Barbara County Department of Behavioral Wellness

Behavioral Wellness Request for Therapeutic Behavioral Services (TBS)

Please TYPE, fill out completely, and attach release of information (ROI)

Submit all documents to:
bwellqcm@sbcbwell.org

Please allow up to 5 business days for the request to be processed

Referring Party Information:

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

Client Information:

Client Name:
Client ID:
DOB:
Preferred Language:

TBS:

Request: Re-authoriza

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: *(Check all that apply)*
☐ 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. *(Note documentation must reflect symptoms/behaviors leading to placing the child/youth at risk for placement in higher level of care.)*

☐ 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. *(Note documentation must reflect symptoms/behaviors leading to placing the child/youth at risk for placement in higher level of care.)*

Service Need:

Describe very specifically and concretely 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): *(Check all that apply, comments)*
☐ Previous treatment/Placement:
☐ Family/Social:
☐ Abuse History:
☐ Substance Abuse:
☐ Current Medication:

☐ Side effects of medication:

☐ Medical Problems:

☐ School/IEP:

☐ Developmental Functioning/IQ:

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 *(Not eligible for TBS)*

To be completed and signed by current specialty 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. I have attached a copy of my current assessment, treatment plan, ROI, and Medi-Cal eligibility for this client.

Mental health provider's electronic signature:

Supervisor's electronic signature:

NOTE: If referring party is not the primary specialty mental health provider, check box below:

☐ Primary specialty mental health provider has been notified of this referral, and has been asked to send current mental health assessment, treatment plan, ROI, and Medi-Cal eligibility in order to complete this referral. **This referral cannot be processed until documentation is complete.**

This Section to be QCM

Approved: No

If no, provide reason denied:
Amount of days/months approved for:
Start Date: End Date:
Quality Assurance Coordinator’s electronic signature: