Therapeutic Behavioral Services (TBS) Monthly Service Authorization

NAME / MRN

TBS Provider Contact/Supervisor

Primary County/CBO Service Provider (Point Person)

Name of TBS Provider Agency

Referring County Clinic/CBO

____________________________________________

DATE ASSIGNED/START DATE: ______________

REPORT DUE DATES:

- PRELIMINARY TREATMENT PLAN: _____________
- FINAL TREATMENT PLAN: _____________
- ADDENDUM TREATMENT PLAN: _____________
- TERMINATION REPORT: _____________

DIRECT SERVICE HOURS MAY NOT BE BILLED UNTIL FINAL PLAN IS SUBMITTED.

Final Treatment plan must be submitted within 30 days from the date client was assigned to your agency. Final Treatment Plans and Addendums to the Treatment Plan may not be submitted in lieu of a monthly report.

NEXT MONTHLY REPORT IS DUE: ______________

AUTHORIZED HOURS FOR TBS:

INITIAL PLANNING HOURS: _____________

HOURS FOR THE REMAINDER OF THE MONTH (NEW CASES ONLY)

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HOURS FOR THE NEXT MONTH:

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<th>Month</th>
<th>Hours</th>
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Authorized by: _____________________________________________ Authorization Date: _____________

Contra Costa TBS Team Lead/Coordinator

For questions about reports or authorized hours contact TBS at:
Main: 925-521-5740
Fax: 925-646-5870
By Encrypted Email only: ContraCostaTBS@hsd.cccounty.us