Referral for Therapeutic Behavioral Services (TBS)

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:
- Initial Clinical Assessment OR Annual Assessment (dated/completed within the last 12 months)
- Partnership Plan for Wellness (TBS as a treatment option and as a strategy in the addendum/update)
- Consent to Participate in Coordinated Services
- Child and Adolescent Needs and Strengths (CANS)
- Current Service Authorization Form (with approval by UR Authorization Committee)

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 group home facility RCL 12 or above and/or locked treatment facility for the treatment of mental health needs.
- Child/youth is being considered by the county for placement in a group home facility of RCL 12 or above 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.

If you are not sure or unable to provide any of the information above, please call or email TBS Coordinator for consultation before completing the referral:

Phone: 925-521-5710
Email: ContraCostaTBS@cchealth.org
Child’s Ethnicity

Current Address

Child’s School

Parent/Caregiver (legal responsible party)

Parent/Caregiver (legal responsible party)

Gender: ☐ Female ☐ Male ☐ Other:

City

Date of Birth

Social Security Number (SSN)

Phone Number

Relationship to child

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.

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Does your child/youth or child’s caregiver have specific requests or needs with regard to 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.

<table>
<thead>
<tr>
<th>Role</th>
<th>Name/Agency</th>
<th>Contact Number</th>
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<tbody>
<tr>
<td>Psychotherapist</td>
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<td>Psychiatrist</td>
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<td>Probation Officer</td>
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<td>Case Manager</td>
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<td>Wraparound Facilitator</td>
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<td>Family Partner</td>
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<td>Intensive Care Coordinator</td>
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<td>In-Home Based Services</td>
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<td>Residential/Placement Contact</td>
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<td>Children &amp; Family Services (CFS) Social Worker</td>
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<td>Name</td>
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<td>Other Person/Service</td>
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</table>
☐ Other Person/Service: ___________________________________________ __________________________ ____________________________

Name/Agency/Role Contact Number

Clinical Need Criteria: If the clinical judgment of the mental health provider indicates that it is highly likely that without the additional short-term support of TBS 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.

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 Relationship to child Date ____________________________ ____________________________ ____________________________

Where to send the referral packet:

By Mail: Attention: TBS Program Contra Costa Behavioral Health 2425 Bisso Lane, Suite 200 Concord, CA 94520
By Fax: (925) 646-5810
By Encrypted Email only: ContraCostaTBS@cchealth.org

TBS PROGRAM USE ONLY

☐ Medi-Cal verified by: __________ Initials

Reviewed and approved by: TBS Team Coordinator Date Approved ____________________________ ____________________________

Agency Assigned Date Assigned ____________________________ ____________________________

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