Referral for Therapeutic Behavioral Services (TBS)

Child’s Last Name, First Name

Primary Service Provider (Point Person), License, Job Title

Medical Record Number (MRN)

Referring Agency

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

- Initial Clinical Assessment
- Annual Assessment (if applicable)
- Partnership Plan for Wellness
  - with TBS selected as a treatment option and/or revision/update includes TBS
  - with Utilization Review (UR) Authorization Committee Signature
- Consent to Participate in Coordinated Services
- Children/Adolescent Medical Necessity Criteria
- Child and Adolescent Level of Care Utilization System (CALOCUS)
- Service Authorization Form (current track and with UR Authorization Committee Signature)

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: 925-521-5740
Email: ContraCostaTBS@hsd.cccounty.us
Referral for Therapeutic Behavioral Services (TBS) continued:

Child’s Name
_________________________________________ __________________________

MRN

Ethnicity

Gender: ☐ Female ☐ Male
☐ __________________________

Current Address
_________________________________________ __________________________ _______________________

City

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 TBS Coach/Specialist’s language, culture, age, or gender?
____________________________________________________________________________________________________
____________________________________________________________________________________________________
____________________________________________________________________________________________________
____________________________________________________________________________________________________
____________________________________________________________________________________________________
____________________________________________________________________________________________________
____________________________________________________________________________________________________
____________________________________________________________________________________________________

MHC058 (Rev 07/2017) Referral for Therapeutic Behavioral Services (TBS)
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.

☐ Psychotherapist: _________________________________________
  Name/Agency                  Contact Number

☐ Psychiatrist: _________________________________________
  Name/Agency                  Contact Number

☐ Probation Officer: _________________________________________
  Name/Agency                  Contact Number

☐ Case Manager: _________________________________________
  Name/Agency                  Contact Number

☐ Wraparound Facilitator: _________________________________________
  Name/Agency                  Contact Number

☐ Family Partner: _________________________________________
  Name/Agency                  Contact Number

☐ Intensive Case Coordinator: _________________________________________
  Name/Agency                  Contact Number

☐ In-Home Based Services
  Name/Agency                  Contact Number

☐ Residential/Placement Contact
  Name/Agency                  Contact Number

☐ Children & Family Services (CFS) Social Worker:
  Name
  County                     Contact Number

☐ Other Person/Service: _________________________________________
  Name/Agency/Role            Contact Number

☐ Other Person/Service: _________________________________________
  Name/Agency/Role            Contact Number
Referral for Therapeutic Behavioral Services (TBS) continued:

Child’s Name

MRN

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.

Primary Clinician (Point Person) __________________________ License/Designation/Job Title __________________________ Date ____________

Email Address __________________________ Fax Number __________________________ Additional Contact Number __________________________

Approved by Clinician’s Supervisor __________________________ License/Designation/Job Title __________________________ Date ____________

Parent/caregiver agreement to participate __________________________ 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) 646-5870

By Encrypted Email only: ContraCostaTBS@hsd.cccounty.us

☐ Medi-Cal verified by: __________________________

Initials

Reviewed and approved by: __________________________
TBS Team Coordinator __________________________ Date Approved ____________

Agency Assigned __________________________ Date Assigned ____________

TBS PROGRAM ONLY