

Child and Family Access Team

Therapeutic Behavioral Services (TBS) Referral Packet (1 of 7)

All TBS Services must be pre-authorized by the Child and Family Access Team

TBS Referral Packet **must** be completed in its entirety in order for services to be authorized

Instructions: List one child per form.
Incomplete forms will be returned for additional information

Access Phone: (916) 875-9980

Access Fax: (916) 875-9970

Please print clearly

Submitting Agency _____

Submitting Program _____

Referring Clinician _____ Phone: _____ Fax: _____

Client Last Name _____ **Client First Name** _____

Client birth name (Last, First) _____ , _____

SSN: _____ - _____ - _____ Date of Birth (M/D/Y) _____ / _____ / _____ Gender: _____

Ethnicity _____ Primary Language _____

Parent/Caregiver's name (Last, First) _____ , _____

Relationship to Client _____ Primary Language (Parent/Caregiver) _____

Street Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Alternate Phone _____

FOR ACCESS USE ONLY

CATS ID # _____ MSO ID # _____

Medi-Cal # _____ BIC Date: _____ Intake Month _____

Reviewed by / Date: _____ / _____ Pending Agency: _____ Program: **TBS**

LINKED Reviewed By _____ Date _____

Agency _____ Program **TBS** Fax # _____

Coordinating Agency/Program _____ / _____ MSO Auth# _____

Start Date _____ End Date _____

DMH Notification Form Completed _____

Initial or quarterly _____ Date Completed _____



Therapeutic Behavioral Services (TBS) Referral Packet (3 of 7)

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Client Last Name _____

Client First Name _____

Yes

No

Is the child / youth a Certified Class Member?

If the child / youth meets any one of the following criteria, check the "yes" box.

How is the child / youth *specifically* a member of the certified class?

Mark appropriate box(es) and explain specifics on lines provided.

Child / youth is placed in a group home facility of RCL 12 or above and / or a locked treatment facility for the treatment of mental health needs which is not an institution for Mental Health Disease.

Child / youth is being considered by the County for placement in a facility RCL 12 or above, and / or locked treatment facility.

Child / youth has undergone at least one emergency psychiatric hospitalization related to his/her current presenting disability within the preceding 24 months.

Child / youth previously received Therapeutic Behavioral Services (TBS) while a member of the Certified Class.

Therapeutic Behavioral Services (TBS) Referral Packet (4 of 7)

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Client Last Name _____

Client First Name _____

Yes No **Is it highly likely, in the clinical judgment of the specialty mental health service provider, that without additional short-term support of Therapeutic Behavioral Services (TBS) one of the following will occur:**

If yes, check the appropriate box below (check one only) and explain specifics on lines provided.

The child / youth will need to be placed in a higher level of residential care, including acute care, because of a change in the child / youth's behaviors or symptoms which jeopardize continued placement in current facility.

The child / youth 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 or symptoms are needed to stabilize the child in the new environment. (The Mental Health Plan (MHP) or its provider must document the basis for the expectation that the behavior or symptoms will change).

Yes No **Does the child / youth have specific target behavior(s) that puts him / her "at risk" for a higher level of placement or "at risk" of being unable to transition to a lower level placement?**

If yes, describe what the **specific target behavior(s)** is/are.

Therapeutic Behavioral Services (TBS) Referral Packet (5 of 7)

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Client Last Name _____

Client First Name _____

Attachments (required):

Yes I have attached the child / youth’s Assessment Client Plan (ACP).

Dated _____

Yes I have attached the child / youth’s most recent Reassessment and Reauthorization (R&R). If services have only been authorized one initial time and an R&R has not been completed, then the R&R is not required for submittal.

Dated _____

Yes I have added a statement to the most recent assessment plan (ACP or R&R) reflecting that TBS services have been requested for the specified target behaviors. Statement is dated and initialed by treating clinician.

Additional Information (required):

Yes No Is the child / youth currently living in a group home?

If yes, name of group home _____ Level _____

Yes No Has the child / youth been to the Sacramento County Mental Health Treatment Center (MERT – Minor Emergency Response Team) within the preceeding 6 months?

If yes, date _____

Explain circumstances in detail _____

Number of “estimated” hours of TBS needed per week _____

Yes No Is the child / youth currently “awaiting placement” (the decision to find a higher level of placement has already been made)?

Therapeutic Behavioral Services (TBS) Referral Packet (6 of 7)

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Client Last Name _____

Client First Name _____

Modified Health Questionnaire Information

Has the child / youth experienced any of the following conditions?

If so, please state age of child / youth and explain.

Age of client		Comments	Age of client		Comments
	Allergies to medications, drugs, food, etc.			German Measles Regular Measles	
	Mumps			Chicken Pox	
	Whooping Cough			Diphtheria	
	Flu			Meningitis	
	Encephalitis (Brain infection)			Polio	
	Chronic ear infections			Hepatitis	
	Visual problems			High Fever	
	Other injuries			Ear Injuries	
	Hearing problems			Poisonings	

Does the Child / youth experience any of the following symptoms? Explain.

Y/N		Explain	Y/N		Explain
	Headaches			Rapid weight loss / gain	
	Visual Problems (blurring, double vision)			Abdominal pains	
	Visual / auditory hallucinations			Joint pains	
	Blackouts / seizures			Chest pains / breathing problems / Asthma	
	Burning sensation on urination			Weakness / tremor / heat intolerance	
	Allergies to medications, drugs, food, etc.			Heart murmurs	
	Hearing problems			Other	

Therapeutic Behavioral Services (TBS) Referral Packet (7 of 7)

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Client Last Name _____

Client First Name _____

Current Medications the child / youth is taking:

(List all prescribed, over-the-counter, and alternative drugs currently using)

Medications	Date Started	Frequency / Strength	Prescribed by / Phone

(If currently prescribed medication) Are there any problems with medications that are currently prescribed? If none, write "none."

Primary Care Physician _____

Phone _____

Does the child / youth have any dental, eye, or hearing problems? Please explain. If none, write "none."

Has child / youth ever been hospitalized (medical or psychiatric)? Yes No

Reason(s) for hospitalization. Please provide dates and location of hospitalization(s). Provide specifics related to reason for hospitalization

Does child / youth have other health issues or concerns?

Please describe any history of serious health problems such as head injuries, heart conditions, etc..
