CONTRA COSTA BEHAVIORAL HEALTH
A Division of Contra Costa Health Services

Referral for Therapeutic Behavioral Services (TBS)

NAME / MRN

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
- ❒ Annual Assessment (if applicable – must be completed within the last 12 months
- ❒ Partnership Plan for Wellness
    - o with TBS selected as a treatment option and/or revision/update includes TBS
- ❒ Consent to Participate in Coordinated Services
- ❒ Children/Adolescent Medical Necessity Criteria
- ❒ Child and Adolescent Needs and Strengths (CANS)
- ❒ 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: 925-521-5742
Email: ContraCostaTBS@cchealth.org

NAME / MRN

_____ Gender: ❒ Female ❒ Male ❒ Other: _____
Child's Ethnicity

_____ _____ _____
Current Address City Zip Code

_____ _____ _____
Child's School Date of Birth Social Security Number (SSN)

_____ _____ _____
Parent/Caregiver (legal responsible party) Phone Number Relationship to child

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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?

_____

_____

_____

_____

_____

_____

NAME / MRN

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

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.

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) 646-5870

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