



ALCOHOL, DRUG & MENTAL HEALTH SERVICES
MARYE L. THOMAS, M.D., DIRECTOR

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(510) 667-7545 FAX (510) 618-3434

INITIAL SCREENING CRITERIA FOR TBS ELIGIBILITY

PLEASE FILL OUT COMPLETELY AND ATTACH CURRENT MENTAL HEALTH TREATMENT PLAN

SUBMIT ALL DOCUMENTATION TO:

Sara L. Wood-Kraft, PhD, TBS Coordinator

(510) 667-7545

SWood_Kraft@acbhcs.org

(510) 618-3434 FAX

CHILD/YOUTH NAME Date of Birth Ethnicity M F

Full-Scope Medi-Cal? yes no (Not eligible for TBS)

SOCIAL SECURITY #

Certified Class Membership. *Child/youth must meet ONE of these criteria:*

- Currently placed in a RCL 12 or above group home and/or locked treatment facility.
- Being considered by the county for a RCL 12 or above group home and/or locked treatment facility
Signature of County Worker or SMHP responsible _____
- One psychiatric hospitalization in the preceding 24 months related to current presenting disability,
Date(s) of hospitalization: _____
- Previously received TBS while a member of the certified class, Date(s) _____
- At risk of requiring psychiatric hospitalization
Signature of SMHP _____

*To be completed and signed by current specialty mental health provider. **Current treatment plan attached.***

Service Need (Check one)

It is highly likely in my clinical judgment that without the additional short-term support of therapeutic behavioral services this child/youth:

- Will need to be placed out of home or in a higher level of residential care, including acute care, because of the change in the youth's behaviors or symptoms which jeopardize placement.
- Needs this additional support to transition to a lower level of residential placement. Although the youth may be stable in the current placement a change in behavior or symptoms is expected and Therapeutic Behavioral Services are needed to stabilize the child in the new environment. (Please provide documentation on page 2)
- None of the above applies (Not eligible for TBS)

If this child/youth is authorized for TBS I agree to collaborate with the TBS provider, which will include regular phone contact. I will write TBS into my treatment plan as an intervention. **I have attached a copy of my current treatment plan for this client.**

Signature of mental health provider

Print Name of mental health provider

Phone _____

e-mail _____

FAX _____

Agency _____



Primary residences for child while receiving TBS (check all that apply)

- Family Home Name, Address & Phone_____
- Foster Home Name, Address & Phone_____
- Foster Family Agency Name, Address & Phone_____
- Group Home, RCL# _____ Name, Address & Phone_____
- Other Name, Address & Phone _____

Describe very specifically and concretely the behaviors(s) that either put current living situation at risk, put transition to a lower level living situation at risk, or behaviors which put client at risk for psychiatric hospitalization:

What services and interventions have been or are currently being provided to address this behavior?

Is this client receiving any services from: Fred Finch Youth Center Lincoln Child Center Seneca Center STARS ?

Significant history or area of need affecting behavior(s): (Check all that apply, comments)

- Previous treatment/Placement _____
- Family/Social _____
- Abuse History _____
- Substance Abuse _____
- Current Medication (please list)_____
- Side effects of medication _____
- Medical Problems_____
- School/IEP_____
- Developmental Functioning/IQ _____

DSMIV Diagnoses for Specialty Mental Health

- Axis I (Primary focus of treatment) _____
- Axis II (Mental retardation & personality disorder)_____
- Axis III (Medical condition)_____
- Axis IV (Psychosocial & Environmental problems)_____
- Axis V _____
- Date diagnosis given _____

Signature of person who completed form_____

Print name of person who completed form _____

Agency: _____

Date: _____

Phone: _____

FAX: _____

RELEASE OF INFORMATION (To be submitted with referral)

Therapeutic Behavioral Services (TBS) are a short-term one-to-one behavior intervention services for eligible Medi-Cal clients with serious emotional problems who are experiencing a stressful transition or life crisis and need additional short-term support to prevent placement in a group home of Rate Classification Level (RCL) 12 through 14 or a locked facility for treatment of mental health needs; or to enable a transition from any of those levels to a lower level of residential care.

TBS are intended to be an additional mental health service which supplements the child/youth's current specialty mental health service by addressing the target behavior(s) or symptoms(s) that are jeopardizing the child/youth's current living situation or planned transition to a lower level of placement. TBS are intended to provide the child/youth with skills to effectively manage the behavior(s) or symptom(s) that is the barrier to achieving residence in the lowest appropriate level. They are intended to be short-term and not to maintain a child/youth at a specified level for the long-term. TBS are to be decreased when indicated and discontinued when the identified behavioral benchmarks have been achieved or are not reasonably expected in the clinical judgment of the TBS provider to be achieved.

If this child/youth is found eligible for TBS and the service is authorized, in order to provide the service as quickly and effectively as possible we ask that you complete the release of information form below.

Our TBS provider, Fred Finch Youth Center is comprised of both professional and paraprofessional personnel. Professional staff have a master's or doctorate in the mental health field and may be licensed, working toward licensure, or license waived. Paraprofessional staff have a variety of education and experiential backgrounds working with young people with special needs. All staff participate in ongoing staff development to assure they are current with best practices and techniques.

Information disclosed by you, your child, and your family while participating in the Therapeutic Behavioral Services program is generally confidential. However, there are exceptions to confidentiality, including, but not limited to reporting suspected child abuse, expressed threats of violence towards an identifiable victim, danger to self or others, and in certain legal proceedings.

To provide integrated and comprehensive services, verbal and written information may be exchanged about your child and family within the **collaborative treatment team** on a need to know basis, and for supervision and consultation purposes. This team is comprised of Fred Finch Youth Center staff and may also include participants from designated partner agencies who are involved in delivering these comprehensive services.

Please **write-in the name of person/agencies** involved in your child/youth's treatment and indicate if you authorize them to obtain/release information to/from Fred Finch Youth Center. Such disclosure is requested for the purpose of exchanging information necessary to appropriately plan for mental health and TBS related services. This consent is subject to revocation by the undersigned at any time and if not earlier revoked, shall terminate one year from the date of signing this release.

Printed Name of Child/ Youth

	Authorize to exchange/release information	
<input type="checkbox"/> Mental Health provider _____	Phone _____	<input type="checkbox"/> yes <input type="checkbox"/> no
<input type="checkbox"/> Parent/Guardian _____	Phone _____	<input type="checkbox"/> yes <input type="checkbox"/> no
<input type="checkbox"/> Child Welfare Worker _____	Phone _____	<input type="checkbox"/> yes <input type="checkbox"/> no
<input type="checkbox"/> Probation Officer _____	Phone _____	<input type="checkbox"/> yes <input type="checkbox"/> no
<input type="checkbox"/> AB3632 Case Manager _____	Phone _____	<input type="checkbox"/> yes <input type="checkbox"/> no
<input type="checkbox"/> Regional Center Case Manager _____	Phone _____	<input type="checkbox"/> yes <input type="checkbox"/> no
<input type="checkbox"/> Group Home Staff _____	Phone _____	<input type="checkbox"/> yes <input type="checkbox"/> no
<input type="checkbox"/> School Staff _____	Phone _____	<input type="checkbox"/> yes <input type="checkbox"/> no
<input type="checkbox"/> Other _____	Phone _____	<input type="checkbox"/> yes <input type="checkbox"/> no

Signed: _____ Print Name: _____
(Parent, Guardian or Legal Representative) (Parent, Guardian or Legal Representative)

Date: _____

Signature of Client: _____ Date: _____
(If applicable)

Witness: _____ Date: _____