ALCOHOL, DRUG & MENTAL HEALTH SERVICES
MANUEL JIMENEZ, M.F.T., 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:
Andrea Kiefer LCSW, TBS Coordinator
(510) 667-7545 akiefer@acbhcs.org 1(888)818-1501 FAX

_____ _____ _____ ☐M ☐F
CHILD/YOUTH NAME Date of Birth Ethnicity

Full-Scope Medi-Cal? ☐yes ☐no (Not eligible for TBS) _____ _____
Preferred language **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.**

_____ Phone _____
Signature of mental health provider e-mail _____
_____ FAX _____
Print Name of mental health provider 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 <u>very specifically and concretely</u> 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_____ Date: _____

Print name of person who completed form _____ Phone: _____

Agency: _____ FAX: _____

Contact Information and Consent Form

(To be submitted with referral)

Therapeutic Behavioral Services (TBS) are adjunct, short-term, one-to-one behavior intervention services for eligible full-scope Medi-Cal clients who receive services from a primary mental health therapist (SMTP). These clients also have serious emotional problems and are experiencing a stressful transition or life crisis and need additional mental health service, i.e. TBS, 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. TBS is also utilized to facilitate transition from any of those levels to a lower level of residential care. TBS is decreased when indicated and discontinued when the identified target behavioral goals have been achieved or will not be, in the clinical judgment of the TBS provider.

Our TBS providers are comprised of both professional and paraprofessional personnel. Professional staff may be licensed, interns working towards licensure, or license-waivered. To provide integrated and comprehensive services, client information may be shared on a need-to-know basis for supervision and consultation. Client information may also be exchanged among participants of designated partner agencies who are involved in delivering this comprehensive service as a collaborative team. Information disclosed by you, the youth, or other family members while participating in TBS is generally confidential, unless exceptions to confidentiality apply. Exceptions to confidentiality include (but are not limited to) reporting suspected child abuse or expressed threats of violence towards self or an identifiable victim, and certain legal proceedings.

Contact Information**

Please **write-in the name of person/agencies** involved in your child/youth's comprehensive treatment. This will allow the TBS provider to make initial contact with the collaborative treatment team.

_____

Printed Name of Child/ Youth

- ☐ Mental Health provider _____ Phone _____
- ☐ Parent/ Caregiver _____ Phone _____
- ☐ Child Welfare Worker (CWW) _____ Phone _____
- ☐ Probation Officer _____ Phone _____
- ☐ AB3632/ERMHS Case Manager _____ Phone _____
- ☐ Regional Center Case Manager _____ Phone _____
- ☐ Group Home Staff _____ Phone _____
- ☐ School Staff _____ Phone _____
- ☐ Attorney _____ Phone _____

Release of Information**

Please sign if you are the parent or legal representative and are authorizing release and exchange of information to/from the TBS provider and the above contacts. This disclosure will allow exchanging information with the collaborative team members to appropriately plan for TBS related services. This release 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

☐ Parent _____ Phone _____

Signed: _____ Print Name:_____

(Parent or legal representative) (Parent or legal representative)

Date: _____

Signature of Client: _____ Date: _____

If client refuses or is unavailable, please explain.

Consent for TBS **

I give consent for _____to receive Therapeutic Behavior Services.

Signed _____ Print Name _____ Date_____

(Parent or Legal Representative) (Parent or Legal Representative)

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.

****NOTE: For Court Dependents, only Contact Information and Consent for TBS is required, not signature on Release of Information.**