alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

INITIAL SCREENING CRITERIA FOR TBS ELIGIBILITY

PLEASE FILL OUT COMPLETELY AND ATTACH CURRENT MENTAL HEALTH TREATMENT PLAN

SUBMIT ALL DOCUMENTATION TO: **TBS Coordinator**

1(888)818-1501 FAX

Contact ACBH TBS Coordinator, Andrea Kiefer for questions at andrea.kiefer@acgov.org or (510)383-5128

☐M ☐F ☐Other

CHILD/YOUTH NAME **DATE OF BIRTH** **ETHNICITY** **GENDER**

Full-Scope Medi-Cal? ☐Yes ☐No (not eligible for TBS)

Preferred Language: _____ **Social Security #** _____

Certified Class Membership: Child/youth must meet at least ONE of the following criteria:

☐ Currently in a STRTP and/or locked treatment facility

☐ Being considered by the County for a STRTP 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 psychiatric hospitalization
Signature of SMHP* responsible: _____

*SMHP = Specialty Mental Health Provider

To be completed and signed by current specialty mental provider. **Current treatment plan attached including a DSM diagnosis and TBS included as an intervention/modality**

Service Need (check one) **In my clinical judgment, it is highly likely 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 phone contact. **I have attached a copy of the client's current treatment plan, which includes a DSM diagnosis and TBS as an intervention.**

Signature of Mental Health Provider **Print name of Mental Health Provider**

e-mail: _____ **Phone:** _____

fax: **Agency:** _____

Primary residence(s) for child receiving TBS (check all that apply)

	Primary Residence	NAME	ADDRESS	PHONE
☐	Family Home			
☐	Foster Home			
☐	Foster Family Agency			
☐	Group Home/STRTP			
☐	Other			

Describe very specifically and concretely the behavior(s) that either put current living situation at risk, or behaviors which put client at risk for psychiatric hospitalization (400 characters max):

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

Client is currently receiving services from:

☐ Fred Finch Youth & Families ☐ Lincoln Families ☐ Seneca Center ☐ Not Applicable

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) _____

☐ Medical Problems _____

☐ School / IEP _____

☐ Developmental Functioning / IQ _____

DSM Diagnoses for Specialty Mental Health

ICD Code: _____ **DX:** _____

ICD Code: _____ **DX:** _____

Date Diagnosis Given: _____

Signature of Person completing form _____ Date: _____

Print Name of person completing form _____ Phone _____

Agency: _____ FAX: _____

TBS Service Description

Therapeutic Behavioral Health Services (TBS) are adjunct, short-term, one-to-one behavior intervention services for eligible full-scope Medi-Cal clients who receive services from a specialty mental health provider (SMHP). 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/STRTP or a locked facility for treatment of their 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, in the clinical judgment of the TBS provider, will not be.

Our TBS providers are comprised of both professional and paraprofessional personnel. Professional staff may be licensed, interns working toward 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 obtain Consent/Release of Information to collaborate with treatment team.

Printed Name of Child/Youth _____

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

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for office use only

ACBH DETERMINATION

☐ Client meets TBS Eligibility criteria

☐ Client does NOT meet TBS criteria

Reason(s): _____

ACBH Administrator Signature _____ **Printed Name** _____ **Date** _____