

Therapeutic Behavioral Services Description and Referral Process

Therapeutic Behavioral Services (TBS) are supplemental specialty mental health services covered under the EPSDT benefit. TBS is an intensive, individualized, one-to-one behavioral mental health service available to children and youth under the age of 21 with serious emotional challenges and their families and have full-scope Medi-Cal.

TBS is never a primary therapeutic intervention and is always used in conjunction with a primary specialty mental health service. TBS is designed to support clients to be successful in their current environment or to transition to a lower level of care.

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 services, i.e., TBS, to prevent placement in a group home/Short Term Residential Treatment Program (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.

Referral Process

The process by which Primary Specialty Mental Health Providers (SMHP) can make referrals to TBS on behalf of their clients is by discussing the service with their clients and guardians and documenting the linkage to TBS services in a TCM progress note which may also necessitate updating the TCM care plan. The SMHP should then submit the TBS referral packet including the completed referral form, the MH Assessment, and the Problem List to the ABH Administrator for review and authorization. Upon ABH approval, one of our contracted TBS Providers will begin their functional behavioral assessment following with providing direct services.

Therapeutic Behavioral Services (TBS) Referral Form

**Instructions: Please fill out completely and attach
Current Mental Health Assessment and Problem List**

Email to: TBSCoordinator@acgov.org or Fax to: 1-888-818-1501

CLIENT INFORMATION

Client's Name:		Date of Birth:	
Client's Preferred Name:		Ethnicity:	
Address:			
Gender Identity	Male	Transgender Male	Non-Binary
	Female	Transgender Female	Other
		Gender Pronouns	He/Him
			She/Her
			They/Them
Full-Scope Medi-Cal?	Yes	No (not eligible for TBS)	
Referring party is a Specialty Mental Health Service (SMHS) Medi-Cal Billing Provider?		Yes	No (not eligible for TBS)
Client's Preferred Language:			Social Security Number
Guardian's Preferred Language:			

CERTIFIED CLASS MEMBERSHIP

Client must meet at least **ONE** of the following criteria. Check all that apply:

<input type="checkbox"/>	Currently in a STRTP and/or locked treatment facility
<input type="checkbox"/>	Being considered by the County for a STRTP and/or locked treatment center facility: Signature of County Worker or SMHP* responsible: X
<input type="checkbox"/>	One psychiatric hospitalization in the preceding 24 months related to current presenting disability: Date(s) of Hospitalization: _____
<input type="checkbox"/>	Previously received TBS while a member of the certified class: Date(s): _____
<input type="checkbox"/>	At risk of psychiatric hospitalization: Signature of <i>Specialty Mental Health Provider</i> (SMHP) Representative: X

SERVICE NEED Check one:

In my clinical judgment, it is highly likely that without the additional short-term support of TBS, this client:

	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 client's behaviors or symptoms which jeopardize placement.
	Needs this additional support to transition to a lower level of residential placement. Although the client may be stable in the current placement, a change in behavior or symptoms is expected and Therapeutic Behavioral Services are needed to stabilize the client in the new environment.
	None of the above applies. (Not eligible for TBS)

If this client is authorized for TBS, I agree to collaborate with the TBS provider, which will include phone contact:

Signature of Mental Health Provider: **X**

Printed Name of Mental Health Provider:

Email:		Phone:	
Agency:		Fax:	

PRIMARY RESIDENCE(S) FOR CLIENT RECEIVING TBS

Primary Residence	Contact Name	Address	Phone
Family Home 1:			
Family Home 2:			
Foster Home:			
Foster Family Agency:			
STRTP/ Group Home:			
Other:			

CURRENT PROBLEM BEHAVIORS					Check all that apply:						
<input type="checkbox"/>	Self-injurious behavior	<input type="checkbox"/>	Property damage	<input type="checkbox"/>	Verbal aggression						
<input type="checkbox"/>	Threat to others	<input type="checkbox"/>	Physical aggression	<input type="checkbox"/>	Withdrawal, isolates self						
<input type="checkbox"/>	Threat to self	<input type="checkbox"/>	Disordered eating	<input type="checkbox"/>	Sexual behaviors						
<input type="checkbox"/>	Disregard for rules (e.g., limits around safety, eloping, hygiene)	<input type="checkbox"/>	Severe restrictions on activities of daily living (e.g., panic attacks, fear to go outside, uncontrollable crying, hyperawareness, hygiene)	<input type="checkbox"/>	Other:						
Describe how the above behavior(s) meet selected criteria in the Certified Class Membership section on page 1:											
What services and interventions have been, or are currently being, provided to address the behavior(s)?											
Client is currently receiving mental health services from:											
Fred Finch	<input type="checkbox"/>	Lincoln	<input type="checkbox"/>	La Cheim	<input type="checkbox"/>	Seneca	<input type="checkbox"/>	Victor	<input type="checkbox"/>	Other:	<input type="checkbox"/>
ICD Code:	<input type="text"/>	DX:	<input type="text"/>								
ICD Code:	<input type="text"/>	DX:	<input type="text"/>								

Program Description

TBS is always provided in conjunction with other specialty mental health services such as individual therapy, family therapy, or wraparound services. TBS is short-term, one-to-one behavior intervention services for eligible full-scope Medi-Cal clients.

	Caregivers have been informed of, and agree with, referral being made.
	Family has been informed of, and agrees with, TBS requirements of up to three meetings a week and minimum weekly caregiver participation/involvement.

CONTACT INFORMATION:

Please enter the name of person/agencies involved in your child/youth's comprehensive treatment:			
Mental Health Provider:		Phone:	
Parent / Caregiver:		Phone:	
Child Welfare Worker (CWW):		Phone:	
Probation Officer:		Phone:	
Case Manager:		Phone:	
Regional Center Case Mgr:		Phone:	
STRTP Staff:		Phone:	
School Staff:		Phone:	
ICC Provider:		Phone:	
Primary Care Physician:		Phone:	
Other:		Phone:	

REQUIRED ATTACHMENTS:

	Current Mental Health Assessment		
	Client Problem List		
Signature of person completing form:	X	Date:	
Printed name of person completing form:		Phone:	
Agency:		Fax:	

For office use only: ABH Therapeutic Behavioral Services (TBS) Referral Form

Client's Name: _____

ABH DETERMINATION

Client meets TBS Eligibility

Client does NOT meet TBS criteria

Reason(s):

 _____
ABH Administrator Signature

Printed Name

Date