SANTA BARBARA COUNTY
DEPARTMENT OF
Behavioral Wellness
A System of Care and Recovery

Alice Gleghorn, PhD
Director

Behavioral Wellness

Request for Intensive Home Based Services (IHBS) or Therapeutic Behavioral Services (TBS)

Submit form and paperwork to:
BWELLQCM@SBCWELL.org

Please type and fill out completely

Referring Party Information:

Date of Referral:
Clinician's Name:
Phone Number:

Client Information:

Client Name:
Client ID:
DOB:

IHBS:

Initial Request:		
If checked, does documentation demonstrate that the initial CFT meeting is scheduled?	Yes	No
Reauthorization:		
If checked, does documentation demonstrates that CFT meetings are being completed?	Yes	No

Required Criteria

Child/Youth is under the age of 21;

Child/Youth is eligible for full scope Medi-Cal services; and

Child/Youth meets medical necessity criteria for Specialty Mental health Services.

AND have at least one of the following qualifiers:

Currently being considered for Wraparound, therapeutic foster care, or TBS.

Currently in or being considered for group home (RCL 10 or above), psychiatric hospital, or 24-hour mental health treatment facility, or has experienced three or more placements within the past 2 months due to behavioral health needs.

Per Behavioral Wellness: client is receiving crisis stabilization or other intervention services that are more intense or frequent due to higher acuity needs; such as SAFTY, Mobile Crisis, or Proactive services.

Additional IHBS Requirements:

Child/youth is receiving or will be receiving IHBS weekly at the clinic?	YES	NO
Provide reason additional IHBS support is needed:		
Casa Pacific is available to provide IHBS after hours, weekends, or supplemental IHBS. Check the boxes of the times and days Casa Pacifica is needed to provide additional services. Mon Time: AM PM Tues Time: AM PM Wed Time: AM PM Thurs Time: AM PM Fri Time: AM PM Sat Time: AM PM Sun Time: AM PM		
Provide child/youth's Clinical Assessment #:		
Provide child/youth's Treatment Plan#:		
Provide child/youth's referral progress note#:		

TBS:

Initial Request:
Reauthorization:

Required Criteria

Child/Youth is under the age of 21;

Child/Youth presents with serious emotional challenges (behaviors);

Child/Youth is eligible for full scope Medi-Cal; and

Child/Youth meets medical necessity criteria for Specialty Mental health Services.

AND meets one of the following class criteria:

Child/Youth is currently placed in an RCL 12 or above group home and needs TBS to prevent placement failure.

Child/Youth is at risk of being placed in an RCL 12 or above group home.

Child/Youth has undergone at least one emergency psychiatric hospitalization related to his/her current presenting mental health diagnosis within the preceding 24 months.

Child/Youth is at risk of psychiatric hospitalization.

Child/Youth has previously received TBS while a member of the certified class.

Additional TBS Requirements:

Child/youth is receiving rehab/therapy services in the clinic?	YES	NO
Provide child/youth's Clinical Assessment #:		
Provide child/youth's Treatment Plan#:		
Provide child/youth's referral progress note#:		

Signatures:

Clinician Name: Date:

Supervisor Name: Date:

This Section to be Completed by Regional Manager		
Approved for IHBS:		
Approved for:	Start Date:	End Date:
Approved by:		Date:
Approved for TBS:		
Approved for:	Start Date:	End Date:
Approved by:		Date:
Request for IHBS/TBS not authorized:		
Please Provide Reason:		
Reviewed by:		Date: