Santa Barbara County Department of Behavioral Wellness
Community Based Organizations (CBOs) Request for Therapeutic Behavioral Services (TBS)

Please TYPE, fill out completely, and attach release of information (ROI)

Submit all documents to:
bwellqcm@sbcbwell.org

Please allow up to 5 business days for the request to be processed

Referring Party Information:

Date of Referral:
Mental Health Provider's Name:
Phone Number:

Client Information:

Client Name:
Client ID:
DOB:
Preferred Language:

TBS:

Request:

Required Criteria

	Child/Youth is under the age of 21;
	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: *(Check all that apply)*	
	Child/Youth is placed in a group home facility of RCL 12 or above group home and/or locked treatment facility.
	Child/Youth is being considered by the county for placement in a facility described above at risk of being placed in an RCL 12 or above group home. *(Note documentation must reflect symptoms/behaviors leading to placing the child/youth at risk for placement in higher level of care.)*

Child/Youth has undergone at least one emergency psychiatric hospitalization related to his/her current presenting mental health diagnosis within the preceding 24 months. Date(s) of hospitalization:
Child/Youth has previously received TBS while a member of the certified class. Date(s):
Child/Youth is at risk of psychiatric hospitalization. *(Note documentation must reflect symptoms/behaviors leading to placing the child/youth at risk for placement in higher level of care.)*

Service Need:

Describe very specifically and concretely the behavior(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(s):
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:

Side effects of medication:
Medical Problems:
School/IEP:
Developmental Functioning/IQ:
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 child/youth's behavior(s) or symptom(s) which jeopardize placement.
Needs this additional support to transition to a lower level of residential placement. Although the child/youth may be stable in the current placement a change in behavior(s) or symptom(s) is expected and TBS are needed to stabilize the child in the new environment.
None of the above applies *(Not eligible for TBS)*

To be completed and signed by current specialty mental health provider: If this child/youth is authorized for TBS I agree to collaborate with 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 assessment, treatment plan, ROI, and Medi-Cal eligibility for this client.
Mental health provider's electronic signature:
Supervisor's electronic signature:
NOTE: If referring party is not the primary specialty mental health provider, check box below: Primary specialty mental health provider has been notified of this referral, and has been asked to send current mental health assessment, treatment plan, ROI, and Medi-Cal eligibility in order to complete this referral. **This referral cannot be processed until documentation is complete.**

This Section to be QCM
Approved:

If no, provide reason denied:	
Amount of days/months approved for:	
Start Date:	End Date:
Quality Assurance Coordinator's electronic signature:	