**\*Please complete all items and include TBS referral form, current assessment, and court order if applicable.**

|  |  |  |  |
| --- | --- | --- | --- |
| Child’s Name: |       | Preferred Name:       |  SSN:       |
| Date of Birth: |       |  Age: |       | Preferred Gender: |       |
| Primary Caregiver: |       | Phone: |       |
| Relationship: | [ ]  Bio [ ]  Foster [ ]  Guardian | [ ]  Adoptive |  Presumptive Transfer YES [ ]  NO [ ]  |
| Accurate Address: |       | City: |       | Zip:  |       |
|  Ethnicity:  |       |   Caregiver’s Preferred Language: |       | Preferred TBS service time: |       |
| School:  |       |  Grade:  |        | IEP [ ]  Yes [ ]  No |  [ ]  Enrolled [ ]  Suspended/Expelled |
| To have initial 30 days of TBS, must be a “yes” for both #1 and #2 below: |
| 1. Does child have Full Scope Medi-Cal? [ ]  Yes [ ]  No |  |  |  |  |  |
| 2. Is child currently receiving EPSDT services (**E**arly **P**eriodic **S**creening, **D**iagnosis & **T**reatment services)? [ ]  Yes [ ]  No |
| [ ]  Therapy | [ ]  Medication | [ ]  Other: |       | ICD-10/DSM 5 Dx: |       |
| **THERAPIST** | **COUNTY SOCIALWORKER** | **PROBATION OFFICER** |
| Name:       | Name:       | Name:       |
| Phone:       | Phone:       | Phone:       |
| Email:       | Email:       | Email:       |
| 3. Please list current medications and name of MD/psychiatrist:       |
| To meet class for additional TBS beyond the initial 30 days, must meet criteria for at least one of the following: |
| 4. Is it highly likely that child will be unable to transition to lower level of care? |  [ ]  Yes [ ]  No |
| 5. Is child currently placed in or being considered for an STRTP? STRTP Facility:       |  [ ]  Yes [ ]  No |
| 6. Was the child hospitalized or considered for hospitalization in a psychiatric facility during the past 24 months? [ ]  Yes [ ]  No  |
|  **Name of hospital and date:**  |       |
| 7. Without TBS is it highly likely that the child will require higher level of care? [ ]  Yes [ ]  No |
| 8. Has the child previously received TBS? |  [ ]  Yes [ ]  No |
| CURRENT PROBLEM BEHAVIORS that are jeopardizing placement or transition based on medical necessity. |
| [ ]  Self-injurious behavior | [ ]  Property damage | [ ]  | Has made allegations of abuse in past |
| [ ]  Threat to others | [ ]  Verbal aggression |  | Explain:       |
| [ ]  Withdrawal, isolates self | [ ]  Physical aggression |  |
| [ ]  Disregard for rules  | [ ]  Other        |
| POSSIBLE AREAS of FOCUS |
| [ ]  Increasing coping strategies | [ ]  Decreasing opposition/defiance | [ ]  |  Community integration |
| [ ]  Increasing social skills | [ ]  Decreasing self-injurious behaviors |
| [ ]  Increasing daily living skills | [ ]  Decreasing property damage |  [ ]  |  Other:       |
| [ ]  Increasing school functioning | [ ]  Decreasing verbal/physical aggression |
| [ ]  Sexual behaviors Explain:      |
| **Print Name Title; Agency** |       | **Email Address:**  |       |

**PSYCHIATRIST**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| **[ ]  Expedite** **Referral** | **Rational:**       |

***\*Incomplete TBS referral packets cannot be processed.*** *Please email all items together to DBH Plan Administration at*

*Email:* *DBHAuthorizations@fresnocountyca.gov**.*

**Referring Therapist Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_

***FOR DBH USE ONLY:* This page to be completed by the URS reviewer at DBH Plan Administration.**

**Child’s Name:** Click or tap here to enter text. **SmartCare ID #:** Click or tap here to enter text.

**Date TBS Referral Received:** Click or tap here to enter text.

**PART I: To approve the referral request, TBS Referral Packet contained all of the following components:**

[ ]  FCMHP Therapeutic Behavioral Services Referral Form, complete with:

 [ ]  Legal name, DOB, Primary Caregiver Name, Phone, Relationship, Address, Caregiver Preferred Language, Grade

[ ]  Confirmation that youth is receiving regular EPSDT services, confirmed treating therapist information and list of current medications with name of MD/prescriber.

[ ]  Confirmation person served meets class for TBS by checking yes for at least one criterion 4-8.

[ ]  Medical necessity evident via current MH assessment: all **CURRENT PROBLEM BEHAVIORS** and **POSSIBLE AREAS OF FOCUS** noted on the TBS Referral Form are contained and fully described in the attached MH assessment.

 [ ]  Yes, assessment is current and contains all identified problem behaviors/areas of focus.

 [ ]  No, assessment is NOT current (does not include identified problem behaviors/areas of focus

[ ]  Court Order is included as applicable (This includes WIC Court Orders, guardian papers or caregiver affidavit)

COMMENTS (Part I): Click or tap here to enter text.

**PART II: TBS is NOT allowable, and the referral will NOT be approved if the URS reviewing the TBS referral request determines any of the following exists (check all that apply):**

[ ]  TBS supplants (replaces; substitutes for) the child/youth’s other mental health services provided by the treating therapist and/or other mental health staff, including when more complex needs are present and better addressed by long-term intensive SMHS such as IHBS or WRAP.

[ ] Services are solely:

* For the convenience of the family or other caregivers, physician, treating provider, or teacher;
* To provide supervision or assure compliance with terms and conditions of probation;
* To ensure the child/youth’s physical safety or the safety of others, e.g., suicide watch;
* To address behaviors that are not a result of the child/youth’s mental health condition (as identified and described in the current MH assessment)

[ ]  The child/youth can sustain non-impulsive self-directed behavior, handle themselves appropriately in social situations with peers, and appropriately handle transitions during the day per current MH assessment.

[ ] The child/youth will never be able to sustain non-impulsive self-directed behavior and engage in appropriate community activities without full-time supervision.

[ ] The child/youth is currently admitted on an inpatient psychiatric hospital, psychiatric health facility, nursing facility, IMD, or crisis residential program.

COMMENTS (Part II): Click or tap here to enter text.

**TBS Referral Request Determination:**

[ ] TBS Referral Approved: Part I Referral packet is complete; No conditions identified in Part II exist. URS may sign approval and forward to TBS provider.

[ ] TBS Referral is NOT Approved: Part I Referral Packet is incomplete; At least 1 condition identified in Part II exist. URS does not sign approval or forward to TBS provider; URS to notify referring therapist of non-approval of TBS request via email and complete NOABD as appropriate.

**URS Reviewer Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Print URS Reviewer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**