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

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 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*](mailto: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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**