

## Alameda County TBS Documentation Authorization for Extended TBS Services

Name of Client:		TBS Provider Agency:	
Age:		TBS Worker/Coach	
1 <sup>st</sup> Authorization Date of TBS		Supervisor	

**1. Please provide a summary of the TBS services provided so far. Please include progress with client and caretaker.**

**2. Why is additional TBS needed?**

**3. What is the termination plan? Please provide clearly established timelines and benchmarks.**

**4. What is the planned date of termination of TBS?**

TBS Worker/Coach Signature:				Date form completed:			
Supervisor Signature:				Date:			
TBS Coordinator Signature:				Date:			
Authorized:		Yes		No		Authorization Termination Date:	
NOABD Completed:			Not needed		Yes		

1/14/2025

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