Behavioral Health Department
Alameda County Health

Request for 4th TBS Authorization

Name of Client:	TBS Provider Agency:	FFYC ◯	Lincoln ◯	VCSS ◯	Seneca ◯	Other:
Age:		TBS Worker/Coach				
1st 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			

10/17/24