alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

2000 Embarcadero Cove, Suite 400
Oakland, CA 94606
510-567-8100 / TTY 510-533-5018
Karyn L. Tribble, PsyD, LCSW

Therapeutic Behavioral Services
Description and Referral Process

Therapeutic Behavioral Services (TBS) are supplemental specialty mental health services covered under the EPSDT benefit. TBS is an intensive, individualized, one-to-one behavioral mental health service available to children and youth under the age of 21 with serious emotional challenges and their families and have full-scope Medi-Cal. TBS is never a primary therapeutic intervention and is always used in conjunction with a primary specialty mental health service. TBS is designed to support clients to be successful in their current environment or to transition to a lower level of care.

TBS are adjunct, short-term, one-to-one behavior intervention services for eligible full-scope Medi-Cal clients who receive services from a specialty mental health provider (SMHP). These clients also have serious emotional problems and are experiencing a stressful transition or life crisis and need additional mental health services, i.e. TBS, to prevent placement in a group home/Short Term Residential Treatment Program (STRTP) or a locked facility for treatment of their mental health needs. TBS is also utilized to facilitate transition from any of those levels to a lower level of residential care. TBS is decreased when indicated and discontinued when the identified target behavioral goals have been achieved or, in the clinical judgment of the TBS provider, will not be.

Our TBS providers are comprised of both professional and paraprofessional personnel. Professional staff may be licensed, interns working toward licensure, or license-waivered. To provide integrated and comprehensive services, client information may be shared on a need-to-know basis for supervision and consultation. Client information may also be exchanged among participants of designated partner agencies who are involved in delivering this comprehensive service as a collaborative team. Information disclosed by you, the youth or other family members while participating in TBS is generally confidential, unless exceptions to confidentiality apply. Exceptions to confidentiality include, but are not limited to, reporting suspected child abuse or expressed threats of violence towards self or an identifiable victim, and certain legal proceedings.

Referral Process

The process by which Primary Specialty Mental Health Providers (SMHP) can make referrals to TBS on behalf of their clients is by discussing the service with their clients and guardians and documenting the linkage to TBS services in a TCM progress note which may also necessitate updating the TCM care plan. The SMHP should then submit the TBS referral packet including the completed referral form, the MH Assessment and the Problem List to the ACBH Administrator for review and authorization. Upon ACBH approval, one of our contracted TBS Providers will begin their functional behavioral assessment following with providing direct services.

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Therapeutic Behavioral Services (TBS) Referral Form

Instructions: Please fill out completely and attach
Current Mental Health Assessment and Problem List
Email to: TBSCoordinator@acgov.org or Fax to: 1-888-818-1501

For questions, please send an email to our TBS Coordinator at TBSCoordinator@acgov.org and your inquiry will be directed to the appropriate team member.

Client's Name:		Date of Birth:	
Client's Preferred Name:		Ethnicity:	
Address:			
Gender Identity: ☐ Male ☐ Female ☐ Transgender Female ☐ Transgender Male ☐ Non-Binary ☐ Other: _____		**Gender Pronouns:** ☐ He/Him ☐ She/Her ☐ They/Them	
Full-Scope Medi-Cal? ☐ Yes ☐ No ***(not eligible for TBS)***			
Referring party is a Specialty Mental Health Service (SMHS) Medi-Cal Billing Provider		☐ Yes ☐ No ***(not eligible for TBS)***	
Client's Preferred Language:		**Social Security Number**	
Guardian's Preferred Language			

Certified Class Membership

Client must meet at least **ONE** of the following criteria. Check all that apply:

☐ Currently in a STRTP and/or locked treatment facility

☐ Being considered by the County for a STRTP and/or locked treatment center facility:

Signature of County Worker or SMHP* responsible: X_____

☐ One psychiatric hospitalization in the preceding 24 months related to current presenting disability:

Date(s) of Hospitalization:_____

☐ Previously received TBS while a member of the certified class:

Date(s): _____

☐ At risk of psychiatric hospitalization:

Signature of *Specialty Mental Health Provider* (SMHP) Representative: X_____

Therapeutic Behavioral Services (TBS) Referral Form
Client Name _____

Service Need Check **one**:

In my clinical judgment, it is highly likely that without the additional short-term support of TBS, this client:	
	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 client's behaviors or symptoms which jeopardize placement.
	Needs this additional support to transition to a lower level of residential placement. Although the client may be stable in the current placement, a change in behavior or symptoms is expected and Therapeutic Behavioral Services are needed to stabilize the client in the new environment.
	None of the above applies. **(Not eligible for TBS)**
If this client is authorized for TBS, I agree to collaborate with the TBS provider, which will include phone contact:	
Signature of Mental Health Provider:	X_____
Printed Name of Mental Health Provider:	

E-mail:		Phone:	
Agency:		Fax:	

Primary residence(s) for client receiving TBS

Primary Residence	Contact Name	Address	Phone
Family Home 1:			
Family Home 2:			
Foster Home:			
Foster Family Agency:			
STRTP / Group Home:			
Other:			

Current Problem Behaviors Check all that apply**:**

☐	Self-injurious behavior	☐	Property damage	☐	Verbal aggression
☐	Threat to others	☐	Physical aggression	☐	Withdrawal, isolates self
☐	Threat to self	☐	Disordered eating	☐	Sexual behaviors
☐	Disregard for rules (e.g., limits around safety, eloping, hygiene)	☐	Severe restrictions on activities of daily living (e.g., panic attacks, fear to go outside, uncontrollable crying, hyperawareness, hygiene)	☐	Other:

Describe how the above behavior(s) meet selected criteria in the Certified Class Membership section on page 1:

What services and interventions have been, or are currently being, provided to address the behavior(s)?

Client is currently receiving Mental Health Services from:

☐ Fred Finch ☐ Lincoln ☐ La Cheim ☐ Seneca ☐ Victor ☐ Other:

DSM Diagnoses for Specialty Mental Health:			
ICD Code:		DX:	
ICD Code:		DX:	

Program Description

TBS is always provided in conjunction with other specialty mental health services such as individual therapy, family therapy, or wraparound services. TBS is short-term, one-to-one behavior intervention services for eligible full-scope Medi-Cal clients.

☐	Caregivers have been informed of, and agree with, referral being made.
☐	Family has been informed of, and agrees with, TBS requirements of up to three meetings a week and minimum weekly caregiver participation/involvement.

Contact Information

Please **enter the name of person/agencies** involved in your child/youth's comprehensive treatment:		
Mental Health Provider:	Phone:	
Parent / Caregiver:	Phone:	
Child Welfare Worker (CWW):	Phone:	
Probation Officer:	Phone:	
Case Manager:	Phone:	
Regional Center Case Manager:	Phone:	
STRTP Staff:	Phone:	
School Staff:	Phone:	
ICC Provider:	Phone:	
Attorney:	Phone:	
Other:	Phone:	

REQUIRED ATTACHMENTS:

☐	**Current Mental Health Assessment**
☐	**Client Problem List**

Signature of person completing form:	X_____	**Date:**	
Printed name of person completing form:		**Phone:**	
Agency:		**Fax:**	

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For office use only: ACBH Therapeutic Behavioral Services (TBS) Referral Form

Client's Name: _____

ACBH DETERMINATION

☐ **Client meets TBS Eligibility**

☐ **Client does NOT meet TBS criteria**

Reason(s):

X _____ _____ _____

ACBH Administrator Signature **Printed Name** **Date**