COUNTY OF SANTA CLARA
Behavioral Health Services

County of Santa Clara Behavioral Health Services Department
Quality Improvement Division, Utilization Management
BHSDUM@HHS.SCCGOV.ORG

☐TBS & ☐TBS-ID SCREENING

☐ Initial Request ☐ Continuing Request

Referring Provider Agency-Program Type:	If other Provider: Staff Completing Form:	
Client Name *(Last, First)*:	SS#:	Gender: Another:
DOB:	Avatar#:	
☐Current Residence: ☐Family Home ☐ Foster Home ☐ STRTP ☐ Residential 12-14 ☐ Other		

B. TBS CLASS MEMBERSHIP (check all that apply)

☐ Currently in a STRTP and/or locked treatment facility.
☐ Being considered by the County for an STRTP and/or locked treatment facility, or at risk of psychiatric hospitalization.
☐ One psychiatric hospitalization in the preceding 24 months related to a current presenting disability.
☐ Previously received TBS while a member of the certified class.
☐ None of the above applies (therefore not eligible for TBS).

C. TBS SERVICE NEED (check all that apply)

It is highly likely in the clinical judgment of the mental health provider that without the additional short-term support of Therapeutic Behavioral Services the client:

☐ Will need to be placed in a higher level of residential care, including psychiatric hospitalization, because of the change in the youth's behaviors or symptoms, which jeopardizes continued placement in the current facility.
☐ Needs this additional support to transition to a lower level of residential placement or from a psychiatric hospital. Although youth may be stable in the current placement, changes in behavior or symptoms are expected and TBS is needed to stabilize the child in the new environment.
☐ None of the above applies (therefore not eligible for TBS)

D. Primary residence(s) for client receiving TBS (Check all that apply)

PRIMARY RESIDENCE	CONTACT NAME	ADDRESS	PHONE
☐ Family Home 1			
☐ Family Home 2			
☐ Foster Home			

☐ Foster Family Agency			
☐ STRTP			
☐ Other			

E. Area of Need (Check all that apply)

☐ Daily Living (School/Vocational)	☐ Behavioral	☐ Independent Living Skills
☐ Living Situation	☐ Social	☐ Emotional
☐ Education/Training	☐ Family Relationships	☐

Referral Level: (Check One)

☐ Level 1 (Hosptial Discharge, Crisis, Must be seen in 5 business days)
☐ Level 2 (Significantly impaired, need supprt, Must be seen in 10 business days)

F. Contact Information, if Available (Fill in all that apply)

Mental Health Provider:	Phone:	
Parent/Caregiver:	Phone:	
Child Welfare Worker:	Phone:	
Probation Officer:	Phone:	
Regional Center CM:	Phone:	
STRTP Staff:	Phone:	
ICC Provider:	Phone:	
Other:	Phone:	

G. Required Attachments

☐ **Current Mental Health Assessment**
☐ **Client Problem List** (must include an eligible diagnosis when referring to a TBS-ID Program*)
☐ **Current IEP** (if applicable)
☐ **Regional Center Assessment** (if applicable)

*Eligible TBS-ID diagnoses include, but are not limited to: Autism Spectrum Disorder, Developmental Disorder, Learning Disability, Intellectual Disability, Language Disorder, Cognitive Disorders, and other types of Intellectual Disabilities or Developmental Delay.

H. Client is currently receiving TBS services from: Please select agency: Choose an item.

☐ **Caregiver(s) have been informed of, and agree with, the referral being made.**

Signature of (LPHA)	**Printed Name of Mental Health Provider**
E-Mail:	**Phone:**