COUNTY OF YOLO

Health and Human Services Agency

CHILD, YOUTH AND FAMILY FORM

REFERRAL FOR THERAPEUTIC BEHAVIORAL SERVICES

Date:		
Name of Child/Youth:		
DOB for Child/Youth:		
Primary Language of Child/Youth:	**Primary Language of Caregiver:**	
Current Location of Client: *(Specify Name of Placement and Type - Home, Hospital, Group Home, IMD, Adult Residential Care Home, Etc.)*		
Address Street:		
City:	**State:**	**Zip:**
Contact Person:	**Phone:**	
If the client is under 18, please complete the information below regarding their parent/guardian:		
Parent's/Guardian's Name:	**Phone:**	
Address Street:		
City:	**State:**	**Zip:**
Does this parent/Guardian hold consent authority for mental health services? ***If no, please indicate consent authority and attach court verification:**	YES	NO
Does this parent/Guardian consent to the referral for Therapeutic Behavioral Services?	YES	NO
Reviewed Therapeutic Behavioral Services information sheet with Guardian?	YES	NO

Clinician Name:

			THE FOLLOWING DOCUMENTS ARE REQUIRED TO SUBMIT THIS REFERRAL
			Diagnosis Summary Form
			Standard Assessment
			Client Plan
			CANS

➢ **SCAN COMPLETED AND SIGNED REFERRAL & REQUIRED DOCUMENTS TO:**
CYFMHAccess@yolocounty.org

AUTHORIZATION FOR THERAPEUTIC BEHAVIORAL SERVICES FROM

Please fill out the information below to qualify for Therapeutic Behavioral Services (must meet A, B, C)

A.	YES	NO	Eligibility for Therapeutic Behavioral Services
1.	☐	☐	**Full scope Medi-Cal beneficiary under age 21 years**
2.	☐	☐	**Meets MHP medical necessity criteria**
B.	**YES**	**NO**	**Which of the following Emily Q class criteria does this client meet?**
1.	☐	☐	**Client is placed in a group home facility of RCL 12 or above and/or a locked treatment facility for the treatment of mental health needs which is an Institution for Mental Disease.** If yes, indicate name of placement:
2.	☐	☐	**Client is being considered for placement in a facility RCL 12 or above, and/or a locked treatment facility *or* RCL 12 placement is a consideration option by placing department.** If yes, indicate name of Agency/Department considering placement options:
3.	☐	☐	**Client has undergone at least one emergency psychiatric hospitalization related to his/her current presenting disability within the preceding 24 months.** If yes, indicate date and hospital OR client's behavior that places them at risk of hospitalization:
4.	☐	☐	**Client has previously received therapeutic behavioral services while a member of the certified class.**
C.	**YES**	**NO**	**Need for Therapeutic Behavioral Services:**
1.	☐	☐	**The Child/Youth is receiving other specialty mental health services**
2.a	☐	☐	**Without the additional short-term support of therapeutic behavioral services, will this client need to be placed in a higher level of residential care, including acute care (psychiatric hospital) because of a change in the child/youth's behaviors or symptoms which jeopardize continued placement in current location/facility?** If yes, please describe behaviors that put client at risk of a higher level of care:
2.b	☐	☐	**Will this client need therapeutic behavioral services as an additional support to help transition to a lower level of residential placement?** If yes, please describe behaviors to address to help ensure the client transitions to and maintains a lower level of care:

Additional Information:

What is the anticipated location of the TBS service delivery? (Include type of facility and address)

Are there any cultural considerations or special accommodations needed to provide TBS to this client and/or family/caregivers? If yes, please describe:

➢ **SCAN COMPLETED AND SIGNED AUTHORIZATION FORM TO:** CYFMHAccess@yolocounty.org

➢ **TO BE COMPLETED BY CHILDREN'S MENTAL HEALTH PROGRAM MANAGER OR DESIGNEE**			
TBS Approved: ☐ **YES** ☐ **NO**			
If No, Reason for Denial	☐ Does not meet TBS		
	☐ Other:		
NOA-BD Completed:	Yes ☐	NO ☐	**Date Sent:**
Clinician Name:			**Title:**
Signature:			**Authorization Number:**
Authorization Period:			**Authorization:** ☐ Initial ☐ Reauthorization