MH 661
Revised 7/26/21

SUPPLEMENTAL THERAPEUTIC BEHAVIORIAL SERVICE (TBS) ASSESSMENT

I. Client Identifying Information

Name: _____ DOB: _____ Age: _____ Sex: ☐ Male ☐ Female

Ethnicity: _____ Full Scope Medi-Cal: ☐ Yes ☐ No

Current Living Situation: _____

Parent/Caregiver: _____ Address: _____ Phone: _____

Other Systems Currently Involved in: ☐ DCFS ☐ Special Education ☐ Probation ☐ Other _____

II. Request Information & TBS Class Eligibility

Type of Request:

☐ Initial Request
☐ Renewal – Units/Duration Exhausted
☐ Renewal – Change in Funding Source/Benefit Plan
☐ Renewal – Other (Please explain): _____

Requested start date for TBS Services: _____

LACDMH will make a determination to approve or deny the request within five (5) business days from receipt.

☐ Expedited request needed: standard 5 business day timeframe could seriously jeopardize the client's life or health or ability to attain, maintain, or regain maximum functioning.

Check all the apply:

☐ The child/youth is currently placed in STRTP or above and/or locked treatment facility for the treatment of mental health needs
☐ Child/youth is being considered by the County for placement in one of the facilities described above
☐ Child/youth has undergone at least one emergency psychiatric hospitalization related to his/her current presenting disability within the preceding 24 months
☐ Child/youth previously received TBS while a member of the certified class
☐ Child/youth is at risk of Psychiatric Hospitalization

III. TBS Clinical Criteria

☐ To prevent out-of-home placement or a higher level of care
☐ To ensure transition to home, foster home, or lower level of care
☐ Does not meet TBS criteria (if marked, specify why not and go to Section V)

Name: **DMH ID#:**

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IV. TBS Assessment

1. Identify the specific behaviors and/or symptoms that jeopardizes continuation of the current placement or the specific behaviors and/or symptoms that interfere with the child or youth transitioning to a lower level of care:

Be sure to include: *Intensity* *Frequency* *Duration* *Where Occurring* *When Occurring*	

2. What other specialty mental health service(s) is client currently receiving? Indicate why child or youth needs TBS in addition to current service(s):

Be sure to include: *Services such as Meds, Wraparound, EBPs, FSP* *Why these services are not sufficient to meet needs* *List other less intensive services that have been attempted*	

3. Identify skills and adaptive behaviors that the child or youth is using now to manage the targeted behaviors and/or symptoms and/or is using in other circumstances that could replace the targeted behaviors and/or symptoms:

Be sure to include: *Replacement Behaviors* *Activities enjoyed* *Strengths of client and family/caregiver* *Available Resources* *Supports* *Interventions that are working*	

4. (Optional) Provide any additional clinical information supporting the need for TBS:

V. Signatures

Signature & Discipline	Date	Co-Signature & Discipline (if required)	Date

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