MH 661
Revised 09/04/12

SUPPLEMENTAL THERAPEUTIC BEHAVIORIAL SERVICE ASSESSMENT

I. Single Fixed Point of Responsibility (SFPR) Information

Agency: _____
Name: _____ Discipline: _____ Telephone #: _____

II. Client Identifying Information

Name: _____ DOB: _____ Age: _____ Sex: ☐ Male ☐ Female
Ethnicity: _____ Full Scope Medi-Cal: ☐ Yes ☐ No (must have Full Scope for TBS services)
Current Living Situation: _____
Parent/Caregiver: _____ Address: _____ Phone: _____
CSW/Probation Officer: _____ Phone: _____
Regional Center/Case Manager: _____ Phone: _____
Other: _____ Address: _____ Phone: _____

III. Child/Adolescent Initial Assessment

Most Recent Clinical Assessment Completed by (*Name of Agency):* _____
Rendering Provider: _____ *Date:*_____
Other documents reviewed: ☐ *MAT* ☐ *Juvenile Justice/Probation* ☐ *DCFS* ☐ *Other* _____
Reviewed on (date): _____

Additional Information/Changes to Initial Assessment:

IV. TBS Class Eligibility

☐ The child/youth is currently placed in Rate Classification Level (RCL) facility of 12 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

V. 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 VIII)

Name: **IS#:**
Agency: **Provider #:**
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VI. 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. Identify what changes in behaviors and/or symptoms TBS is expected to achieve and how the child's therapist or treatment team will know when these services have been successful and can be reduced or terminated:

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

VII. Diagnosis

☐ Diagnosis is the same as on the Child/Adolescent Initial Assessment or Diagnosis Information Form dated _____

☐ Diagnosis is different from the Child/Adolescent Initial Assessment or Diagnosis Information Form dated _____

(Complete MH 501 Diagnosis Information Form by an AMHD)

VIII. Signatures

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

Name: **IS#:**

Agency: **Provider #:**

Los Angeles County – Department of Mental Health