Attachment 3

THERAPEUTIC BEHAVIORAL SERVICES
IMPLEMENTATION PLAN SUGGESTED FORMAT

Mental Health Plan_____Date_____

1) Which providers will determine the need for therapeutic behavioral services? (Check all that apply)
   County Clinics _____
   Current Contract Providers _____
   New Contract Providers _____

2) Which providers will deliver therapeutic behavioral services? (Check all that apply)
   County Clinics _____
   Current Contract Providers _____
   New Contract Providers _____

3) How and when will providers be informed of their new responsibilities with regards to therapeutic behavioral services? (Complete information for all that apply)
   County Clinics

   Current Contract Providers

   New Contract Providers

4) Estimated Hourly Rate of Staff Persons Providing TBS _____

5) Training or Technical Assistance Requests (optional)

For more information about this plan, call

Name_____Phone_____

SUBMIT THIS FORM by September 1, 1999 to:

Nancy Mengebier
Department of Mental Health
1600 9th Street, Room 100
Sacramento, CA 95814
Phone (916) 654-3486 FAX (916) 653-9194

*If form is handwritten, please make sure the handwriting is legible.