Attachment 4

NOTIFICATION TO DMH

REGARDING PROVISION OF THERAPEUTIC BEHAVIORAL SERVICES

Child/Youth's Name_____

Social Security Number or Beneficiary Identification Number _____

Beginning Date of Therapeutic Behavioral Services_____

County/MHP Code or Name_____Date_____

Form Completed by (Name)_____ Phone_____

Primary Residences for Child/Youth While Receiving TBS (Check All That Apply)

Family Home_____,
Foster Home_____,
Foster Family Agency_____
Children's Shelter_____
Group Home_____specify RCL_____
Other Specify_____

Class Membership (Check One)

In RCL 12 or above_____
Being Considered for RCL 12 or above_____
One Psychiatric Hospitalization in Preceding 24 months_____
Previously received TBS while Class Member_____

Service Need (Check One)

To Prevent Placement in a Higher Level of Care_____
To Enable Transition to a Lower Level of Care_____

TBS Service Plan

Planned Average Hours of TBS per Week _____
Estimated # Weeks of TBS_____

Initial Information_____ OR Quarterly Update_____

SUBMIT THIS FORM within the first thirty days of service and every quarter thereafter to:

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

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