TBS Referral Form Instruction

1. **Date** the Form
2. Add **Referring Party Name** and **Referring Party's Phone Number**. *This contact information will be utilized by the Utilization Review (UR) Team to obtain additional information as needed to approve/deny/defer the referral. The UR team will also use this info to inform referring party when the Family has been opened to services by the TBS provider. The TBS provider will use this contact information should they need additional info, such as when experiencing difficulties with contacting client/family.*
3. Add the referring party's **Supervisor Name** and **Number**. *This will allow addition contact options should referring party be unavailable.*
4. Add **Client's Name**, **Case Number**, **Medi-Cal Number, Address, City, State, Zip code, DOB, Gender,** and **Ethnicity**. *This information ensures that all agencies are able to communicate and send correspondence efficiently; the Medi-Cal number allows the provider to verify client's eligibility which is a requisite for an individual to receive TBS.*
5. Add **Primary Caregiver Name** and **Phone Number**, and mark an indicator as to the status of that Caregiver/client relationship (are they with **Bio** parent, **Adoptive** parent, **Step** parent, **Resource Family**, Intensive Therapeutic Foster Care (**IFTC**), Kinship Guardianship Assistance Payment Program (**Kin-gap**), or is the child a **Dependent of the Court**
6. Add **CFS: Social Worker Name**, **Phone Number, and Fax Number** if applicable. *If the child is Presumptive Transfer they will have an Out of County Social Worker, their contact info must be provided as the TBS provider will need to obtain their signature to open the child to TBS services.*
7. Add **School Name**, child's **Grade Level**, and mark any applicable indicators pertaining to their education status (is there an **IEP**, are they **Enrolled** in school, are they currently **Suspended/Expelled)**. *This information will assist the TBS provider when creating a thorough assessment/plan for service delivery based and the child's individual needs.*
8. Add **Contact** information for *all* **Agencies Involved**. **This should include the referring clinician or other service provider**. *The TBS provider will need the contact information for anyone who may be important to connect with to assist in determining treatment needs and coordinating service delivery.*
9. **Indicate whether the client is under 21 and has full scope Medi-Cal***. This is the initial verification that client meets this basic, yet imperative, TBS requirement.*
10. **Indicate whether the client is receiving Specialty Mental Health Services**. *A client is not eligible to the more intensive service of TBS if they are not already eligible for and receiving Specialty Mental Health Services.* ****Again, if the answer to step 9 or 10 is No, then the client is not eligible to receive TBS services.**
11. **List the client's current DSM Diagnosis and the ICD 10 code.** *Since the client is required to be receiving Specialty Mental Health Services, they should have an existing Medi-Cal covered Diagnosis.*
12. **Mark all indicators relating to the conditions that client has met**. *these indicators qualify the client for TBS Class Eligibility, and at least one of them must be met:*
    - *If choosing the condition relating to risk of psychiatric hospitalization or having had a psychiatric hospitalization in the last 24 months, you must also include the Dates for the corresponding hospitalizations or urgent care/crisis service. This could be further expanded on in the narrative section later in the form.*

- *Indicate if client is currently in a group home/STRTP*
- *If choosing the condition that indicates client is being considered for placement in a level 12 or above group home, appropriate supporting documentation of a PPRT **must** be provided. If the child is adopted and the determination has been made at a Youth Clinical Care meeting, the YCC notes must be attached. Fill in the Date of the meeting and mark the box indicating that the documentation has been attached.*
- *Indicate if the client has previously received TBS services. If you have verification of TBS received in another county, please include it.*

13. **Indicate, regardless of class eligibility criteria selected, whether the client is <u>currently</u> at risk of needing out of home placement or a higher level of residential or acute care.** *This supports medical necessity for the treatment.*
14. **Indicate which Specialty Mental Health Services the client has received in the last 6 months.** *Indicating the services already implemented also supports the initial screening for medical necessity for the more intensive TBS services.*
15. **In the final narrative box, give specific details regarding the behaviors that client is exhibiting which is jeopardizing placement and supports the class eligibility chosen.** *These details support medical necessity and allows Utilization Review to make an informed decision regarding approval of the referral.*
16. **Once the form is complete, fax the completed form and all supporting documentation (asx., PPRT, YCC notes, etc.) to the Utilization Review team at (530) 225-5950.** *Faxing the form to the UR team, rather than sending it to one staff members email, will ensure that the referral is processed timely regardless if someone is out of the office unexpectedly.*
17. **Finally, send an email informing UR that a referral has been faxed, using mceur@co.shasta.ca.us.** *This will alert us to an issue if the fax is never received, therefore, preventing a delay in service delivery to the client.*