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.