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.