THERAPEUTIC BEHAVIORAL SERVICES (TBS)
REFERRAL FORM

New Alternatives, Inc.

* Indicates a required section

*Youth Name: _____ *Youth's DOB: _____

*Current Address: _____

Youth's School: _____ School District: _____

*Parent/Caregiver Name: _____ *Parent Caregiver Phone: _____

Referring Party:

*Name: _____ *Agency: _____ *Relationship to Youth: _____

*Phone: _____ *Email: _____ *Fax: _____

Agencies Involved:

Therapist: (If same as Referring Party, leave blank)

*Name: _____ *Agency: _____ *Relationship to Youth: _____

*Phone: _____ *Email: _____ *Fax: _____

CWS Involved: ☐ Yes ☐ No

Name: _____ Phone: _____ Email: _____ Fax: _____

Any Other Persons Involved (CASA, Mentor, Attorney, Probation, Big Brother/Sister)

Name: _____ Phone: _____ Fax: _____

Name: _____ Phone: _____ Fax: _____

***Is Youth a full scope Medi-Cal beneficiary under age 21?** ☐ Yes ☐ No ***Medi-Cal Number** _____

***Is Youth receiving Specialty Mental Health Services from a therapist/intensive case manager?** ☐ Yes ☐ No

***Which of the following conditions have been met by the Youth?** (check all that apply – must check minimum of one)

- ☐ Is at risk for emergency psychiatric hospitalization as one possible treatment option, though not necessarily the only treatment option **or** has had at least one emergency psychiatric hospitalization within the past 24 months.
- ☐ Is being considered for placement in a level 12 or above group home as one possible treatment option, though not necessarily the only treatment option, **or** is currently placed in a level 12 or above group home for mental health needs.

***Does the Youth meet either of the following eligibility criteria?** (check which apply-must check a minimum of one)

- ☐ Youth may need out of home placement, a higher level of residential or acute care
- ☐ Youth is transitioning to a lower level of care and needs TBS to support the transition

***What specific behaviors are jeopardizing the Youth's current living placement?** (Please be specific)

_____

_____

_____

Specific requests with regard to TBS Coach's language, culture, gender, or age:

_____

Attach a Release of Information and ensure that all required sections are completed

Fax Referral Packet to: New Alternatives, Inc. – Therapeutic Behavioral Services (TBS) at: **(619) 615-0897**

Please call TBS Referral Specialist at **(619) 615-0701 x535** with any questions