**LETTER OF REQUEST FOR TBS SERVICES**

To type within the TBS Referral, please single (left) click within the grey underlined box and start typing.

**For Care Manager use only:**      **DD**

**Initial record #**       **/**     **MH**

**Client’s Name:**       **DOB:**      **/**     **/**      **Gender: *Male*[ ]  *Female*[ ]**

**Race:**       **Medical Assistance#:**

**DSM-V Diagnoses:**

**Current medications:**

**Referring Agency:**

**Referring Provider:**       **Phone:**      **-**     **-**

**Current Therapist:**       **Agency:**       **Phone:**      **-**     **-**

**Therapist Email Address:**

**TBS Provider Requested: Therapeutic Connections Requested Hrs. of Service:**

**Please select, from the options below, specific behaviors that warrant intensive, in-home, one-to-one behavioral support services and describe in detail:**

[ ]  Risk of Out-Of-Home Placement:

[ ]  Involvement with Law Enforcement:

[ ]  Property Destruction:

[ ]  Fire Setting

[ ]  Difficulty with Focus/Concentration:

[ ]  Poor Impulse Control:

[ ]  Physical Aggression:

[ ]  Verbal Aggression:

[ ]  Physical/Verbal Conflict with Peers:

[ ]  Self-Injurious Behavior:

[ ]  Suicidal Ideations:

[ ]  Homicidal Ideations/Attempts:

[ ]  Sexually Inappropriate Behavior:

[ ]  Running Away:

[ ]  Suspension, Expulsion, Lack of Promotion to Next Grade:

[ ]  Opposition/Defiance to Authority:

[ ]  Inability to Manage Stressors:

[ ]  Stealing:

[ ]  Lying/Manipulation:

[ ]  Other:

**Please describe intensity, frequency, and duration of each behavior checked above:**

**Do these behaviors this place the child at risk of out-of-home placement? Why?**

**List interventions or programs already in place for the recipient:**

**Does the client receive PRP at this time? Yes**[ ]  **No**[ ]

**What’s the name of the provider?**

**TBS Interventions Requested: (check all that apply):**

**[ ]** Individualized Behavior Assessment

[ ]  Conflict Management Development

[ ]  Parent Education/Support

[ ]  Implementation of Behavior Plans

[ ]  Crisis Intervention

[ ]  Coping Skills Training

[ ]  Therapeutic Role Play

[ ]  Communication Skill Development

[ ]  Problem-Solving Training

**[ ]** Client Psychoeducation

[ ]  Academic Support

[ ]  In-Home Structure Development and Implementation

**Brief description of recipient’s behavioral history: (include placement history/*hospitalizations*, previous services)**

**Please describe recipient’s behavior in school: (include if the client has a 504 Plan, IEP and if the IEP has behavioral goals, if known)**

**Is the client in family therapy? Yes**[ ]  **No**[ ]  **Frequency of sessions?**

**What has been the family’s response to treatment?**

**Please concretely state the family’s investment and participation in treatment: (Comment is necessary to demonstrate guardian’s investment for the purpose of insurance authorization)**

**Legal Guardian? Yes**[ ]  **No**[ ]

**Name of legal guardian if not person above:**

**Address of legal guardian:**       **Phone #:**     **-**     **-**

**Parent or Guardian who will be working with the aide in the home:**

**Name:**       **Relationship:**

**Address:**      **Phone#:**      **-**     **-**

**Identify Treatment Foster Care, Therapeutic Group Home, or facility if applicable:**

**Name of Facility:**       **Phone #:**     **-**     **-**

**Address:**

**I certify that I am requesting TBS for the above client and have completed this letter of request for TBS: [Must be an independently licensed clinician (MD, PhD, LCPC, LCSW-C, CRNP, APRN)]**

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**Signature of referring clinician/license Date**

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**Co-signer /License Date**

**(required for clinicians without independent license, i.e. LGPC, LGSW)**

**Please fax this request with a CURRENT PSYCHOSOCIAL to:**

**TBS Care Manager Therapeutic Connections, LLC**

**VALUEOPTIONS and FAX#: (443) 288-4676**

**FAX #: 1-877-502-1044**