Print Form

TBS Consideration Prior to Placement

Certification Form

I, _____, certify on behalf of San Bernardino County Department of Behavioral Health that for:
PRINTED NAME OF QUALIFIED PRACTITIONER — NAME OF MENTAL HEALTH PLAN

Name of Child/Youth_____ SSN_____ Date of Birth_____

Check 1, 2, 3, or 4:

☐ 1. TBS has been provided and the placement is still required.

☐ 2. To the best of the MHP's knowledge, the child/youth is only eligible for Medi-Cal when the child/youth is in out-of-home placement; therefore the child/youth would not be eligible for TBS while at home

☐ 3. TBS has been considered and has been determined to be inappropriate because (Check all that apply):

- ☐ Services would be solely for the convenience of the family or other caregivers, providers or teachers.
- ☐ Services would be solely to provide supervision or assure compliance with terms of probation.
- ☐ Services would be solely to ensure the child/youth's physical safety or the safety of others.
- ☐ Services are needed solely to address conditions that are not part of the child/youth's mental health condition.
- ☐ TBS services will not resolve the child/youth's transition issues or prevent the child/youth from moving to a higher level of care.
- ☐ The child/youth/family refuses to participate in the full range of services specified in the treatment plan as necessary to address the child/youth's mental illness.
- ☐ The child/youth is currently in a nursing facility or mental health rehabilitation center that has been designated as an institution for mental diseases (IMD) and, therefore, is not eligible for TBS to maintain this placement (DMH Letter 99-04, "TBS and Residents of IMDs").
- ☐ Other_____

☐ 4. TBS is appropriate but (Check all that apply):

- ☐ Was refused by family/caregiver or the child/youth (when appropriate).
- ☐ According to the placing agency, the placement must occur.
- ☐ Is not available because_____

Signature_____ Date_____

License Number and Type or Job Title_____

A copy of this Certification Form has been provided to:

Child/Youth: Name:_____Date:_____

Legally Authorized Adult: Name:_____Date:_____

Court Appointed Attorney: Name:_____Date:_____

Social Worker/Probation Officer: Name:_____Date:_____

Original Chart

CCICMS Certification File

Send to: Department of Mental Health
Systems Implementation & Support
1600 Ninth Street Room 100
Sacramento, Ca 95184