CONTRA COSTA
BEHAVIORAL HEALTH
A Division of Contra Costa Health Services

# Therapeutic Behavioral Services (TBS) Monthly Service Authorization

NAME / MRN

**TBS Provider Contact/Supervisor**

**Primary County/CBO Service Provider (Point Person)**

**Name of TBS Provider Agency**

**Referring County Clinic/CBO**

**DATE ASSIGNED/START DATE:** _____

**REPORT DUE DATES:**

- PRELIMINARY TREATMENT PLAN: _____
- FINAL TREATMENT PLAN: _____
- ADDENDUM TREATMENT PLAN: _____
- TERMINATION REPORT: _____

**DIRECT SERVICE HOURS MAY NOT BE BILLED UNTIL THE PRELIMINARY TREATMENT PLAN IS SUBMITTED.**

**Final Treatment plan must be submitted within 30 days from the date client was assigned to your agency. Final Treatment Plans and Addendums to the Treatment Plan may not be submitted in lieu of a monthly report.**

## NEXT MONTHLY REPORT IS DUE: _____

**AUTHORIZED HOURS FOR TBS:**

INITIAL PLANNING HOURS: _____

HOURS FOR THE REMAINDER OF THE MONTH (NEW CASES ONLY) _____ **Month** _____ **Hours**

HOURS FOR THE NEXT MONTH: _____ **Month** _____ **Hours**

HOURS FOR THE SUBSEQUENT MONTH: _____ **Month** _____ **Hours**

Authorized by: _____ Authorization Date: _____
**Contra Costa TBS Team Lead/Coordinator**

For questions about reports or authorized hours contact TBS at:
Main: 925-521-5740
Fax: 925-646-5870
By Encrypted Email only: ContraCostaTBS@hsd.cccounty.us