

Therapeutic Behavioral Services (TBS) Initial Release Form

Dear Parent or Guardian _____
(Name of Parent or Legal Guardian)

With your permission, I would like to refer your **child** _____ for TBS with one of Butte County Department of Behavioral Health Contract Providers. This service is available for Full Scope Medi-Cal ONLY eligible children.

If your child does not qualify for the above services you will be contacted to discuss alternative therapeutic services available to you. If you have any questions please contact Butte County Department of Behavioral Health's TBS coordinator at 530-879-2456.

Referring Party Signature

Date

Parent/Guardian Permission Slip

I give my permission for (_____) to refer my child to Butte County Department of Behavioral Health and one of their Organizational Providers to possibly provide TBS services. I understand that I will be contacted to set up an appointment to gather information and to complete the necessary paperwork.

CHILD'S NAME: _____ **Date of Birth:** _____

MEDI-CAL Card #: _____ **Issue Date:** _____

Parent or Guardian Signature

Phone #



Verbal permission and Medi-Cal information was obtained via phone from Parent / Legal Guardian.

Information verified by: _____ **Date:** _____

(Signature of Agency Staff if no signature by guardian)

Butte County Department of Behavioral Health
Initial TBS Release / Permission Slip

Client Name: _____

Client Number: _____