

**T. B. S. CHECKLIST TO DOCUMENT T.B.S. CATEGORY-  
CONSIDERATION FOR RCL 12 PLACEMENT**

1. Child's current behaviors or symptoms jeopardize continued placement in current home or out-of-home placement. \_\_\_ yes \_\_\_no
  
2. Child has a previous history of at least one RCL 12 placement. \_\_\_ yes \_\_\_no  
\_\_\_ ineligible due to age
  
3. Child currently resides in another lower level RCL group home (versus foster or family home). \_\_\_ yes \_\_\_no  
\_\_\_ ineligible due to age
  
4. Child has been staffed in Interagency Placement Council in the last 3 years. \_\_\_ yes \_\_\_no
  
5. Child has a history of 2 or more out-of-home placements. \_\_\_ yes \_\_\_no

**I certify that this client should qualify for the above TBS category on the basis of the above.**

Signature of Clinician or SSP \_\_\_\_\_ Date: \_\_\_\_\_  
Printed Name/Title/Licensure \_\_\_\_\_ Agency/Clinic: \_\_\_\_\_

**If the above signature is not a licensed clinician, a co-signature by the clinician's supervisor or SSP's supervisor is needed below.**

Signature of CS, CTII or SSSP \_\_\_\_\_ Date: \_\_\_\_\_  
Printed Name/Title/Licensure \_\_\_\_\_

**Disclaimer: Your signature(s) ensure(s) that there is congruent information in your records which justifies your answers.**

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Therapeutic Behavioral Services  
Consideration for RCL 12 Placement Checklist

Confidential Patient Information  
See W&I Code 5328

NAME:

DOB:

AGENCY:

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*The section below is to be completed to show agreement by the TBS provider:*

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It is highly likely in the clinical judgment of the mental health provider that without the additional short-term support of TBS that:

The child will need to be placed in a higher level of residential care [specifically RLC 12] because of a change in the child's behaviors or symptoms which jeopardize continued placement in current facility. A change in behavior or symptoms is expected and therapeutic behavioral services are needed to stabilize the child in the [current] environment. *Note: The provider must document the basis for the expectation that the behavior or symptoms will change, in their own record (per DMH letter #04-11 dated 10-21-04).*

Signature of TBS Provider\_\_\_\_\_ Date:\_\_\_\_\_

Printed Name/Title/Licensure\_\_\_\_\_

**If the above signature is not a licensed clinician, a co-signature by the licensed supervisor is needed below.**

Licensed Supervisory Signature of TBS Provider\_\_\_\_\_ Date:\_\_\_\_\_

Printed Name/Title/Licensure\_\_\_\_\_

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