CONTRA COSTA HEALTH
MENTAL HEALTH SERVICES

Therapeutic Behavioral Services (TBS) Addendum Treatment Plan

NAME / MRN

TBS Agency | TBS Specialist/Coach | Date

Point Person

Eligibility

- ☐ At risk of psychiatric hospitalization (5150 or 5585)
- ☐ At risk of STRTP placement
- ☐ Psychiatric hospitalization in past 24 months
- ☐ Enable transition to lower level of care
- ☐ Previously received TBS while member of a certified class

Current Residence

- ☐ Immediate family
- ☐ Extended family
- ☐ Foster home
- ☐ STRTP
- ☐ Other: _____

Service Recommendation

Total hrs/week: _____ (_____ Hrs/day, _____ Days/week)

Estimated # of weeks of TBS: _____ (not to exceed 12 weeks)

Location of Services**:**

- ☐ Residence
- ☐ School
- ☐ Other: _____

Current Treatment Team

- ☐ Psychiatrist
- ☐ Therapist
- ☐ Social Worker
- ☐ Wraparound
- ☐ Other: _____
- ☐ Other: _____

Updates to Identifying Information:

Updates to Client/Family Strengths:

Updates to Target Behavior (Baseline):

Behavior:

NAME / MRN

Frequency:

Mild:

Moderate:

Severe:

Duration:

Latency:

Triggers:

Function:

Updates to Adaptive Behaviors, reactive strategies, and interventions:

NAME / MRN

Is reinforcement required: ☐ **No** ☐ **Yes** *(please describe)*

Updates to Goal*:*

Updates to Anticipated Barriers to Success:

Updates to Fade-Out and Transition Plan:

Additional Information:

NAME / MRN

Therapeutic Behavioral Services (TBS) Addendum Treatment Plan Signature Page

TBS Agency

Client Signature	Print Name	Date
Parent/Caregiver Signature	Print Name	Date
TBS Specialist Signature	Print Name/Licensure/Designation	Date
TBS Clinical Supervisor Signature	Print Name/Licensure/Designation	Date

CLINICIAN USE ONLY

If the client/parent does not sign this plan, document reason why: