CONTRA COSTA
BEHAVIORAL HEALTH
A Division of Contra Costa Health Services

Therapeutic Behavioral Services (TBS) Addendum Treatment Plan

NAME / MRN

TBS Agency | **TBS Specialist/Coach** | **Date**

Eligibility

- ☐ At risk of psychiatric hospitalization (5150)
- ☐ At risk of placement RCL 12 above facility
- ☐ 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
- ☐ Group home (RCL_____)
- ☐ 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: _____

Identifying Information *(Updates only.)*

NAME / MRN

New Target Behavior #1

Behavior:
Frequency:
Intensity & Severity:
Duration:
Latency:
Triggers:
Function:

New Target Behavior #2 (if applicable)

Behavior:
Frequency:
Intensity & Severity:
Duration:
Latency:
Triggers:
Function:

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Adaptive Behaviors and Interventions: *(Updates only.)*

Individual:
Environmental:

Goal and 30-day Benchmark *(Update as needed.)*

Goal:
Initial 30-day Benchmark:

Fade-Out and Transition Plan *(Describe when TBS interventions and hours will be reduced and terminated, using specific behavioral criteria. Describe how the client/family will be prepared for termination of TBS and ready to maintain the progress achieved.)*

(TBS may also be terminated if reasonable progress is not occurring and the treatment goal is not reasonably expected to be achieved.)

NAME / MRN

Information Continued from Previous Pages

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SIGNATURE PAGE

TBS Agency

Client/Consumer 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**
Behavioral Consultant Signature	**Print Name/Licensure/Designation**	**Date**
Contra Costa TBS Team Lead/Coordinator	**Print Name/Licensure/Designation**	**Date**

***Document reason for no consumer/parent signature on this plan.**