

Therapeutic Behavioral Services (TBS) 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

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 Residence

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

Current Treatment Team

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

Identifying Information: Age: _____ Race/Ethnicity: _____

Gender: Gender: Male Female Transgender Non-binary Other _____

Living Situation:

Client/Family Strengths:

Target Behavior (Baseline):

Behavior:

Frequency:

Mild:

Moderate:

Severe:

Duration:

Latency:

Triggers:

Function:

Adaptive Behaviors, reactive strategies, and interventions:

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

Goal:

Anticipated Barriers to Success:

Fade-Out and Transition Plan:

NAME / MRN

Additional Information:

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: