Therapeutic Behavioral Services (TBS) Monthly Report

NAME / MRN

TBS Agency **TBS Specialist/Coach** **Reporting Month/Year**

Current Status:

❑ Behavioral Goals Achieved ❑ Progress Made ❑ No Change ❑ Regression

Residence/Placement Changes:

Current Residence (who is child living with during this reporting month?):
Placement changes during this reporting month:
Psychiatric emergency/psychiatric hospitalizations during this reporting month:

Goal and Benchmark

Goal(s) from treatment plan:

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Benchmark(s) from prior 30 days:

Monthly Summary of Services

Current Progress *(Describe frequency, duration, and severity of target behavior(s) with data, as well as where/with whom target behavior(s) have occurred, over the past 30 days. Short narrative of functional replacement behaviors used.):*

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New 30-day Benchmark *(Benchmark may stay the same if not met this reporting period.)*

Adaptive Behaviors and Interventions *(Discuss what adaptive/replacement behaviors/skills are being used. Describe how these behaviors haven been taught, rehearsed, cued/prompted, and reinforced. Describe how generalization is promoted. Describe success interventions during this reporting period; discuss efforts at involving caregivers in interventions.):*

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Barriers to Success *(List any barriers to success that were evident in this reporting period. Discuss how these barriers were addressed.):*

Plans for Fade-Out *(Discuss current fade-out plan and any ways that are different than what is written on the Service Plan and attached Revised Treatment Plan if there are substantial differences. Discuss treatment changes during fade-out, including systematic reduction in service hours, changes in interventions, and reinforcement systems to promote independence, etc. If fade-out is not yet taking place, discuss why not, as well as efforts toward preparing both client and caregivers for impending termination):*

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Collateral Contacts *(Discuss contact with point person, caregivers, therapists, school personnel, etc.):*

Other Services Current and Recommended *(Include therapeutic services, wraparound, medication evaluation, parenting classes, mentoring, respite for caregivers, academic support, life skills training, etc.):*

Initial Authorization/Assigned Date: _______________

Number of Hours of TBS to Date: _______________

Approximate Termination Date: _______________

Number of Weeks of TBS to Date: _______________

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Information Continued from Previous Pages

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SIGNATURE PAGE

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TBS Agency

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TBS Specialist Signature	**Print Name/Licensure/Designation**	**Date**
______________________________	______________________________	__________
TBS Clinical Supervisor Signature	**Print Name/Licensure/Designation**	**Date**