Therapeutic Behavioral Services (TBS) Final 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 *(Gender, age, race/ethnicity, living situation, DSM Diagnoses, disabilities, past trauma, treatment history, client/family strengths, and any anticipated barriers to success.)*

NAME / MRN

Target Behavior #1

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

NAME / MRN

Target Behavior #2 (if applicable, otherwise delete this section)

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

NAME / MRN

Adaptive Behaviors and Interventions: *(Describe how adaptive behaviors/replacement behaviors will be taught, rehearsed, cued/prompted, and reinforced. How will triggers be managed? What are the reactive strategies to the target behavior? Describe interventions that will be used with the client, caregivers, and others to meet the treatment goal, and how effectiveness will be evaluated.)*

Individual:
Environmental:

NAME / MRN

Goal and 30-day Benchmark *(The **Goal** is the expected and necessary reduction of the target behavior(s) in terms of frequency, duration, and severity. The **Benchmark** should describe what activities will take place and what the client/family is expected to accomplish in the first 30 days (after the Plan date) to support achievement of the Goal. Subsequent Monthly Reports should document progress on the benchmark, and if achieved a new 30-day benchmark should be identified.)*

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.)*

Information Continued from Previous Pages

NAME / MRN

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.**