

Therapeutic Behavioral Services (TBS) Addendum Treatment Plan

NAME / MRN _____

 TBS Agency

 TBS Specialist/Coach

 Date

 Point Person

Eligibility

- At risk of psychiatric hospitalization (5150)
- 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: _____

Updates to Identifying Information:

Updates to Client/Family Strengths:

Updates to Target Behavior:

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 _____

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

*Document reason for no client/parent signature on this plan: