CONTRA COSTA HEALTH
MENTAL HEALTH SERVICES

Therapeutic Behavioral Services (TBS) 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

Current Residence

- ☐ Immediate family
- ☐ Extended family
- ☐ Foster home
- ☐ STRTP
- ☐ 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: **Age:** _____ **Race/Ethnicity:** _____

Gender: Gender: ☐ Male ☐ Female ☐ Transgender ☐ Non-binary ☐ Other_____

Living Situation:

Client/Family Strengths:

Target Behavior:

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Frequency:

Mild:

Moderate:

Severe:

Duration:

Latency:

Triggers:

Function:

Adaptive Behaviors, reactive strategies, and interventions:

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

Goal*:*

Anticipated Barriers to Success:

Fade-Out and Transition Plan:

Additional Information:

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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:**

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