



Therapeutic Behavioral Services (TBS) Addendum 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 *(Updates only.)*

New Target Behavior #1

Behavior:

Frequency:

Intensity & Severity:

Duration:

Latency:

Triggers:

Function:

New Target Behavior #2 (if applicable)

Behavior:

Frequency:

Intensity & Severity:

Duration:

Latency:

Triggers:

Function:

Adaptive Behaviors and Interventions: (Updates only.)

Individual:

Environmental:

Goal and 30-day Benchmark *(Update as needed.)*

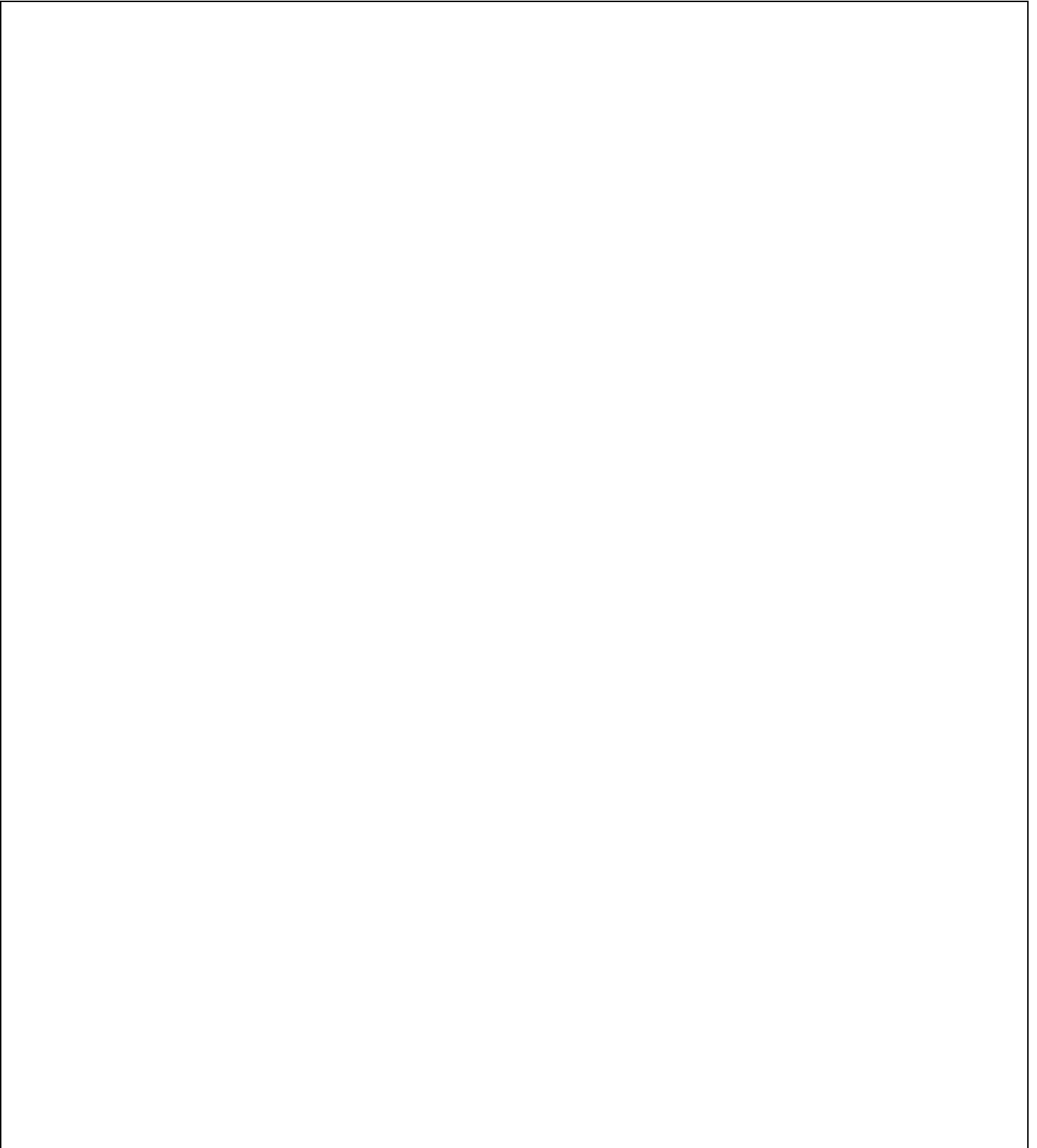
Goal:

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.)*

(TBS may also be terminated if reasonable progress is not occurring and the treatment goal is not reasonably expected to be achieved.)

Information Continued from Previous Pages



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.