Therapeutic Behavioral Services (TBS) Preliminary Treatment Plan

NAME / MRN

TBS Agency	TBS Specialist/Coach	Date

Target Behavior:

Describe behavior in detail: include frequency and severity of behavior and how behavior jeopardizes placement. What are hypothesized triggers and function of the behavior?

Triggers/Precipitants to Behavior:

Please identify all known or reported triggers or precipitants to the target behavior.

Strengths/Motivators/Environmental Supports:

List all known strengths, motivators, and environmental supports that currently exist in client's life.

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Interventions:

(Please clarify specific interventions to resolve behavior.)

Positive Replacement Behavior:

(Please list specific alternative behavior(s) to currently identified maladaptive behavior.)

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Measurable Outcomes:

(Describe the projected reduction in frequency and severity of the target behavior.)

Anticipated Barriers to Success:

(Please identify all obstacle(s) to treatment as well as how you plan to address this issue(s).)

Fade-Out/Transition Plan:

(Describe when TBS 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.)

Service Recommendation: Total hrs/week: ______ (Hrs/day______ Days/week______)

NAME / MRN

Information Continued from Previous Pages

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SIGNATURE PAGE

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TBS Agency

____________________________________	____________________________________	____________
TBS Specialist Signature	**Print Name/Licensure/Designation**	**Date**
TBS Clinical Supervisor Signature	**Print Name/Licensure/Designation**	**Date**
Contra Costa TBS Team Lead/Coordinator	**Print Name/Licensure/Designation**	**Date**