

# THERAPEUTIC BEHAVIORAL SERVICES (TBS) TREATMENT PLAN

## Subsequent Authorization

Treatment Team Meeting Date: \_\_\_/\_\_\_/\_\_\_

Authorization # 2             Authorization #3             Authorization #4 (must submit for state DMH approval)

Authorization Period \_\_\_/\_\_\_/\_\_\_ through \_\_\_/\_\_\_/\_\_\_            (Authorizations may not exceed 60 days)

TBS Hours Recommended: \_\_\_\_\_ hours per week (*includes travel and documentation time*)

Licensed or Licensed Eligible Staff: (printed name) \_\_\_\_\_

*The following target behaviors are jeopardizing current living situation or transition to a lower level of care. Target behaviors must be specific, observable and measurable, and be consistent with specialty MHS goals.*

**TARGET BEHAVIOR #1**            Check one:     Revised             Continued

**Review of Progress/Remarks/Summary** (*Does problem behavior still exist? Is target behavior improving in frequency, intensity or duration? If not, does service need to be changed? Why/why not?*)

\_\_\_\_\_

\_\_\_\_\_

**Maladaptive Behavior** (*include **current** Frequency / Duration / Intensity*): \_\_\_\_\_

**Antecedent** (*what happens just before the target behavior occurs*): \_\_\_\_\_

**Replacement Behavior** (*alternative adaptive behavior and/or alternative incompatible behavior*): \_\_\_\_\_

**TBS 60 Day Treatment Goal** (*with Baseline & Measurable Outcomes*): By (date) \_\_\_\_\_, (end of authorization period)

**Interventions:** (*Examples of Interventions: Reinforcing desirable behavior, redirection, ignoring undesirable behavior, relaxation, choice making skill development, communication skills for making requests, development of alternative, adaptive behaviors, development of alternative, incompatible behaviors, setting limits, differential reinforcement of alternative, incompatible behavior, differential reinforcement for absence of behavior, stimulus control including removal of antecedent events, adjustment to setting or demands on youth, offering choices or decision making, removing excessive or provocative stimulation.*)

1.

**List of Rewards /Incentives for Positive Behavior for Goal #1:**

*(The following should be individualized in accordance with the child's ability to maintain positive behavior, with additional incentives developed for increasing periods of success. The child and the caregiver need to participate and agree with this list. The caregiver should enter the numerical equivalent on the weekly "Behavior Chart".)*

**Mental Health Systems, Inc.  
Therapeutic Behavioral Services  
Treatment Plan**

**Confidential Patient Information  
See W&I Code 5328**

**NAME:**

**CHART NO:**

**DOB:**

**AGENCY:**

Initial Plan Dated: \_\_\_\_\_

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1.

Actual Completion Date (fill in when goal is dropped): \_\_\_\_\_

.....

**TARGET BEHAVIOR #2**      Check One:     New                     Revised                     Continued

**Review of Progress/Remarks/Summary** (Does problem behavior still exist? Is target behavior improving in frequency, intensity or duration? If not, does service need to be changed? Why/why not?)

\_\_\_\_\_

\_\_\_\_\_

**Maladaptive Behavior** (include **current** Frequency / Duration / Intensity): \_\_\_\_\_

**Antecedent** (what happens just before the target behavior occurs): \_\_\_\_\_

**Replacement Behavior** (alternative adaptive behavior and/or alternative incompatible behavior): \_\_\_\_\_

**TBS 60 Day Treatment Goal** (with Baseline & Measurable Outcome): By (date) \_\_\_\_\_, (end of authorization period)

**Interventions:** (Examples of Interventions: Reinforcing desirable behavior, redirection, ignoring undesirable behavior, relaxation, choice making skill development, communication skills for making requests, development of alternative, adaptive behaviors, development of alternative, incompatible behaviors, setting limits, differential reinforcement of alternative, incompatible behavior, differential reinforcement for absence of behavior, stimulus control including removal of antecedent events, adjustment to setting or demands on youth,, offering choices or decision making, removing excessive or provocative stimulation.)

1.

**List of Rewards /Incentives for Positive Behavior for Goal #2:**

(The following should be individualized in accordance with the child's ability to maintain positive behavior, with additional incentives developed for increasing periods of success. The child and the caregiver need to participate and agree with this list. The caregiver should enter the numerical equivalent on the weekly "Behavior Chart".)

1.

Actual Completion Date (fill in when goal is dropped): \_\_\_\_\_

.....

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**TARGET BEHAVIOR #3**      Check One:     New                       Revised                       Continued

**Review of Progress/Remarks/Summary** *(Does problem behavior still exist? Is target behavior improving in frequency, intensity or duration? If not, does service need to be changed? Why/why not?)*

\_\_\_\_\_

\_\_\_\_\_

**Maladaptive Behavior** *(include current Frequency / Duration / Intensity):* \_\_\_\_\_

**Antecedent** *(what happens just before the target behavior occurs):* \_\_\_\_\_

**Replacement Behavior** *(alternative adaptive behavior and/or alternative incompatible behavior):* \_\_\_\_\_

**TBS 60 Day Treatment Goal** *(with Baseline & Measurable Outcome):* By (date) \_\_\_\_\_, (end of authorization period)

\_\_\_\_\_

\_\_\_\_\_

**Interventions** *(Examples of Interventions: Reinforcing desirable behavior, redirection, ignoring undesirable behavior, relaxation, choice making skill development, communication skills for making requests, development of alternative, adaptive behaviors, development of alternative, incompatible behaviors, setting limits, differential reinforcement of alternative, incompatible behavior, differential reinforcement for absence of behavior, stimulus control including removal of antecedent events, adjustment to setting or demands on youth, offering choices or decision making, removing excessive or provocative stimulation.)*

1.

**List of Rewards /Incentives for Positive Behavior for Goal #3:**

*(The following should be individualized in accordance with the child's ability to maintain positive behavior, with additional incentives developed for increasing periods of success. The child and the caregiver need to participate and agree with this list. The caregiver should enter the numerical equivalent on the weekly "Behavior Chart".)*

1.

**Actual Completion Date** *(fill in when goal is dropped):* \_\_\_\_\_

.....

**FADING PLAN** *(Has the service been decreased since the last service plan? (Document how and why hours are being reduced.) How will the service be decreased as improvement is made within the next authorization period? If progress is not observable, how will that be addressed?)* \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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**TRANSITION PLAN (MUST BE COMPLETED IN INITIAL AND ALL SUBSEQUENT PLANS):**

1. Address in measurable terms how and when TBS will be decreased and ultimately discontinued, either when the identified benchmarks have been reached or when reasonable progress toward goals is not occurring and are not expected to be achieved (in the clinical judgment of the TBS Advisor).
2. Address how parents/caregivers will be assisted with skills and strategies to provide continuity of care when service is discontinued.
3. Include transition planning to adult services for children approaching adulthood.

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**COMMENTS** (Have alternatives to TBS been considered, especially if progress has not been made as expected? Include justification why TBS is still being requested, instead of or in addition to other alternatives):

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Client helped develop and agrees with the goals:  Yes  No (If no, see progress note dated: \_\_\_\_\_)

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**Team Participants:**

<u>Name (printed)</u>	<u>Name (signed)</u>	<u>Role</u>	<u>Date</u>
_____	_____	Client _____	_____
_____	_____	Parent/Guardian _____	_____
_____	_____	Therapist _____	_____
_____	_____	TBS Advisor _____	_____
_____	_____	TBS Coach _____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

### Treatment Plan Author (Licensed or Licensed Eligible Staff)

Signature / Title \_\_\_\_\_ Date: \_\_\_\_\_

Name (printed) \_\_\_\_\_

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