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.

Interventions:
(Please clarify specific interventions to resolve behavior.)
Positive Replacement Behavior:
(Please list specific alternative behavior(s) to currently identified maladaptive behavior.)

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_______)
### SIGNATURE PAGE

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**TBS Agency**

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**TBS Specialist Signature**

Print Name/Licensure/Designation

Date

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**TBS Clinical Supervisor Signature**

Print Name/Licensure/Designation

Date

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**Contra Costa TBS Team Lead/Coordinator**

Print Name/Licensure/Designation

Date