PATIENT I.D. DATA:

(Name, DOC#, DOB)

INDIVIDUAL BEHAVIOR MANAGEMENT PLAN

DATE	FACILITY

Primary Therapist: ______________________

Psychologist: ______________________

Plan Expiration date: ______________________

PASTE PHOTO HERE

Rationale for plan/situational background:

Trigger(s):

Consequence(s) of behavior(s) (obtains/avoids):

Function(s) of the behavior(s):

Incentives:

Skills Deficit:

Teaching Target:

Action steps:

Skills Deficit:

Teaching Target:

Action steps:

PATIENT SIGNATURE: ______________________ DATE SIGNED: __________

MULTIDISCIPLINARY TEAM SIGNATURES

PRIMARY THERAPIST (PRINT NAME)	SIGNATURE	DATE
PSYCHOLOGIST (PRINT NAME)	SIGNATURE	DATE
PSYCHIATRIC PRACTITIONER (PRINT NAME) ☐ check if none	SIGNATURE	DATE
CUS/CMHUS (PRINT NAME)	SIGNATURE	DATE

State law and/or federal regulations prohibit disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law.

PATIENT I.D. DATA:

(Name, DOC#, DOB)

SHIFT/UNIT SGT (PRINT NAME)	SIGNATURE	DATE
MEDICAL (PRINT NAME)	SIGNATURE	DATE
CLASSIFICATION COUNSELOR (PRINT NAME)	SIGNATURE	DATE
CHIEF OF PSYCHOLOGY* (PRINT NAME) *If 3rd renewal or more	SIGNATURE	DATE
OTHER (PRINT NAME AND TITLE)	SIGNATURE	DATE

State law and/or federal regulations prohibit disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law.