



PATIENT I.D. DATA:
(Name, DOC#, DOB)

INDIVIDUAL BEHAVIOR MANAGEMENT PLAN

DATE	FACILITY
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Primary Therapist: _____

PASTE PHOTO HERE

Psychologist: _____

Plan Expiration date: _____

Rationale for plan/situational background:

Trigger(s):

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

Function(s) of the behavior(s):

Incentives:

Current Behavior:

Target Behavior:

Action steps:

Current Behavior:

Target Behavior:

Action steps:

PATIENT SIGNATURE: _____

DATE SIGNED: _____

MULTIDISCIPLINARY TEAM SIGNATURES

PRIMARY THERAPIST (PRINT NAME)	SIGNATURE	DATE
PSYCHOLOGIST (PRINT NAME)	SIGNATURE	DATE
PSYCHIATRIC PRACTITIONER (PRINT NAME) <input type="checkbox"/> 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:
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SHIFT/UNIT SGT (PRINT NAME)	SIGNATURE	DATE
MEDICAL (PRINT NAME)	SIGNATURE	DATE
CLASSIFICATION COUNSELOR (PRINT NAME)	SIGNATURE	DATE
CHIEF OF PSYCHOLOGY* (PRINT NAME) *If 3 rd renewal or more	SIGNATURE	DATE
OTHER (PRINT NAME AND TITLE)	SIGNATURE	DATE

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