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| **ID/DD Waiver Behavior Support Plan** |

| **Name:** |  | **Behavior Consultant:** |  |
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| **Medicaid #:** |  | **Agency:** |  |
| **Address:** |  | **Contact Number:** |  |
| **Phone Number:** |  |  |

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| **Background** |
| Reason for Referral: |  |
| History: |  |
| Psychiatric Diagnoses: |  |

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| **Summary of Functional Behavior Assessment** |
| Target Identification Methods: |  |
| Description of Assessment Procedures: |  |
| Target Behavior(s) and Definitions: | Behavior(s) | Definitions |
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| Behavioral Findings: | Behavioral Description | Antecedents | Consequences |
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| Relevant Findings from Physiological Issues/Illness/Injury Assessment: |  |
| Relevant Findings from Environmental and Setting Assessment: |  |
| Relevant Findings from Communicative Functions:  |  |
| Hypothesis and Summary of Behavior Function(s): |  |
| Baseline Data: |  |
| Replacement Behaviors Identified: |  |
| **Tracking and Reduction** |
| Behavior Reduction: |  |
| Baseline Data: |  |
| Intervention Expectation: |  |
| Replacement/Alternative Behavior: |  |
| Review Criteria: |  |

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| Behavior Reduction: |  |
| Baseline Data: |  |
| Intervention Expectation: |  |
| Replacement/Alternative Behavior: |  |
| Review Criteria: |  |
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| Behavior Reduction: |  |
| Baseline Data: |  |
| Intervention Expectation: |  |
| Replacement/Alternative Behavior: |  |
| Review Criteria: |  |

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| **Objective(s)** |
| 1. |  |
| 2. |  |
| 3. |  |
| 4. |  |

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| **Staff Instructions** |
| Preventive Measures: |  |
| Replacement Behavior/Alternative Skill Training: |  |
| Consequence Strategies: |  |
| Procedural Safeguards: |  |
| Medication Side Effects of Concern: |  |

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| **Agreements and Signatures** |
| **I agree with the content of this Plan and give consent for its implementation. I have received a copy of the plan. I understand the behavior management techniques that will be used with this program. I may terminate the program at any time.** |
| Person: |  | Date: |  |
| Person/Legal Representative: |  | Date: |  |
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| **I agree to implement the Plan as described. If any modifications are necessary, I will contact the person/family before making any changes. I will ensure staff is trained before terminating my services.** |
| Behavior Support Consultant: |  | Date: |  |
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| **I agree to the contents of this Plan and will support the Consultant/Interventionist as needed to ensure implementation of the Plan. Appropriate staff will receive training to ensure the Plan continues, as needed, after the Consultant/Interventionist terminates services.** |
| Program Director: |  | Date: |  |

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| Behavior Consultant/Credential |  | Date: |  |
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| **❖BIDD Use Only❖** |
| **Approved** | **Denied** |
|  |  |
| **Signature of BIDD Staff** | **Signature of BIDD Staff** |