FCBDD

Rev. 3/1/16

**BEHAVIORAL ASSESSMENT REPORT**

**Name:**       **DOB:**       (**CA:**      )

**Home/Provider:**

**Guardian** (if applicable):      (Name, phone, & e-mail)

**Service Coordinator:**       (Name, phone, & e-mail)

**ISP Span dates:**       to       (mm/dd/yyyy)

**Evaluated by****:**       (Name, phone, & e-mail)

**Date(s) Evaluated:**

**Date of Report:**       (Use for annual tracking)

**Initial**  **Annual**  **Revision**

**I. REASON FOR ASSESSMENT**

**II.** **DESCRIPTION OF INDIVIDUAL (CASE HISTORY/BACKGROUND RELEVANT TO CURRENT REFERRAL)**

**A. Current residence; family members/housemates; current day placement (school, work, other); personal preferences/most important people, activities, places, etc.:**

**B. Relevant strengths/needs in the following areas:**

**1. Communication:**

**2. Fine/gross motor/sensory:**

**C. Psychological/psychiatric information:**

1. **CURRENT level of intellectual disability & relevant developmental disabilities:**
2. **Trauma history:**

**3. CURRENT mental health diagnoses:**

**4. CURRENT/PAST mental health treatment (s) - please note effectiveness of each:**

**D. Medical information relevant to current referral:**

**1. Medical diagnoses/symptoms currently exhibited:**

**2. Non-prescription medications/supplements taken at time of behavioral assessment. (Please indicate if non-prescription med/supplement list is not available or not applicable.):**

|  |  |  |
| --- | --- | --- |
| **Name of med/supplement** | **Suggested by** | **Symptoms to improve**  **or reduce** |
|  |  |  |
|  |  |  |

**3. Prescription medications taken at time of behavioral assessment:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of med/dose** | **Prescribed by/specialty** | **Dx. For Prescribing (per DSM or ICD codes)** | **Symptoms to improve**  **or reduce** |
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**III.** **PREVIOUS GENERAL and/or RESTRICTIVE SUPPORTS – SUMMARY**

|  |  |  |  |
| --- | --- | --- | --- |
| **Dates** | **Target Behavior(s) / Need** | **Strategy** | **Results** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**IV. DESCRIPTION OF IDENTIFIED NEED/TARGET BEHAVIOR (list top to bottom the most to least dangerous/risky):**

|  |  |  |  |
| --- | --- | --- | --- |
| **Need/Target Behavior**  (category/specific(s),  i.e., ATO/hitting) | **Antecedents** | **Baseline**  **(X/Day/Wk/Mo);**  **Date(s)** | **Poses serious**  **danger/leads to**  **legal involvement** |
|  |  |  | Yes  No |
|  |  |  | Yes  No |
|  |  |  | Yes  No |
|  |  |  | Yes  No |
|  |  |  | Yes  No |

**V. ASSESSMENT RESULTS:**

**A. Methods/tools used/dates:**

**B. Hypothesis regarding function of each identified need/target behavior (be sure to include trauma-informed reasons):**

**VI. SUMMARY STATEMENT:**

**VII. RECOMMENDATIONS**

**Are there sufficient data to indicate that positive teaching and supports have been demonstrated to be ineffective prior to the recommendation/use of restrictive strategies?**

**Yes** **No** **Explain:**

**Not applicable – no restrictive support strategies recommended at this time.**

**If checked, only this Behavioral Assessment Report and Strategies Summary Sheet should be completed and sent to service coordinator.**

1. **Any additional assessments that evaluator/team feels would be helpful to this individual at this time (note type of evaluation and what result is desired, i.e., rule out medical/mental health conditions impacting behaviors/needs):**

1. **Miscellaneous suggestions that might be helpful for this individual at this time:**

1. **STRATEGIES SUMMARY:**
2. **REPLACEMENT SKILLS to teach (just list here):**
3. **REINFORCERS:**
4. **GENERAL INTERVENTION STRATEGIES: Please list general preventives in Section VIII-C, not in this summary chart. List identified needs in order from most to least dangerous/risky.**

|  |  |  |
| --- | --- | --- |
| **Identified Need / Defined as \_\_\_**  i.e., ATO/hitting, pushing | **Strategy/Intervention** | **Location**  to be Used |
|  |  |  |
|  |  |  |
|  |  |  |

1. **RESTRICTIVE PREVENTION AND INTERVENTION STRATEGIES\*: List identified needs in order from most to least dangerous/risky.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Identified Need / Defined as \_\_\_\_**  i.e., ATO/hitting, pushing | **Category/Specific(s)\*\***  i.e., MAR/2-person escort | **Location**  to be Used | **Fade**  (if appl.) |
|  |  |  |  |
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|  |  |  |  |

**\*Require Human Rights Committee (HRC) approval prior to use.**

**\*\*Note all that apply for each need/behavior from these categories: Chemical restraint (CR); Manual restraint (MAR); Mechanical restraint (MER); Time out (TO); Rights restriction (RR).**

1. **DETAILS OF RECOMMENDED STRATEGIES**

**\*For each identified need for use by persons supporting this individual in specific settings.**

**\*List strategies step by step from least to most restrictive.**

1. **Replacement skills –note who will teach & methods for teaching**
2. **Reinforcers – include schedule for use**
3. **General Preventives – to always have in place to help this person be successful (list in order from most to least important at this time and separate by location as needed):**
4. **Identified Need #1 (category/defined as for this person):**
5. **Restrictive Preventives: (note if not applicable; separate by location as needed)**
6. **Intervention strategies – general AND restrictive (list in order from least to most restrictive for each need)**

**List each additional identified need and complete a table as for Identified Need #1.**

**Persons not currently on this individual’s team who later become responsible for overseeing and/or implementing the support strategies recommended in this Assessment Report are to be trained and that training must be recorded on the Behavioral Support Strategies (BSS) Training Documentation Form.**

**BEHAVIORAL ASSESSMENT REPORT CONTINUES ON NEXT PAGE WITH TEAM SIGNATURES**

**TEAM REVIEW/SIGNATURES**:

The individuals listed below have had the opportunity to participate in the review of all sections of this Behavioral Assessment Report. By signing below, each individual agrees to implement recommendations as written and trained, if that is his/her role:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Team  Members | Date  Signed | Signature/Agency | AGREE | AGREE WITH CONDITIONS  (COMMENTS BELOW) | DISAGREE  (COMMENTS BELOW) |
| Individual\* |  |  |  |  |  |
| Parent/guardian (as applicable)\* |  |  |  |  |  |
| Service  Coordinator OR Supervisor\* |  |  |  |  |  |
| Primary Author/  Monitor of Support Strategies\* |  |  |  |  |  |
| Primary Author/ Monitor’s Supervisor\*\* |  |  |  |  |  |
| Implementers’  Supervisor\* |  |  |  |  |  |
| Implementer |  |  |  |  |  |
| Implementer |  |  |  |  |  |
| Implementer |  |  |  |  |  |
| Implementer |  |  |  |  |  |
| Implementer |  |  |  |  |  |
| Advocate  (state relationship) |  |  |  |  |  |
|  |  |  |  |  |  |

\* Required signatures. These must be secured prior to submission of packet for HRC review.

\*\* Unless specialist is independently licensed/qualified to complete assessment and recommend restrictive supports. Please note whether the supervisor’s signature is “not applicable (N/A).” If specialist is a county-funded biller working under a contracted vendor, the signature of the contracted provider is required when restrictive supports have been recommended.

**COMMENTS/CONDITIONS**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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