| PERSON GETTING SERVICES | REPORT DATE | REVISION DATE |
| --- | --- | --- |
| AGE | DATE OF BIRTH | ADSA ID NUMBER |
| PROGRAM NAME | AUTHOR OF REPORT | TITLE | PHONE NUMBER (WITH AREA CODE) |

Functional Assessment and Positive Behavior Support Plan

| **Description of the person:**  *Introduce the person in their best light.*  |
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|  |
| **Behaviors assessed:** *List all behaviors being assessed at this time. Include how data was collected for each behavior.*  |
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| **What does the person like?** *Please be specific.* | **What does the person dislike?** *Please be specific.* |
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| --- |
| **History of the beginning and Maintenance of Behavior(s) of Concern** |
| Current medical conditions |
| Medical condition | Behavior implications |
|  |  |
| Current mental health conditions |
| Mental health condition | Behavior implications |
|  |  |
| Significant life events affecting development of Behavior(s) of Concern |
| Life event | Behavioral impact |
|  |  |

| **Medication and PRNs for behavioral change***For a complete list of medications, please read the current Medication Administration Record* |
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|  |  |
| --- | --- |
| Medication name | Behavioral impact |
|  |  |

| **Prioritized behaviors of concern for the current plan year**  |
| --- |
| **Behavior of Concern 1: Operationally define the behavior.** |
| **Linked to the following guiding values:**  |

|  |  |
| --- | --- |
| Antecedents and triggers | Behavior |
|  |  |
| Maintaining consequence | Why this behavior works |
|  |  |
| **Skills related to behavior of concern****Check the box that best reflects the person’s skill level. Describe the impact that strength or suggested areas of improvement may have on the plan.**  |
| **Skill area** | **Effect on plan** |
| Cognitive skills | Strengths: Supports needed: |
| Communication | Strengths: Supports needed:  |
| Coping skills | Strengths:Supports needed: |
| Social skills | Strengths:Supports needed: |

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| --- |
| **Hypothesis statement** |
| When (antecedents to the behavior of concern) the individual (behavior of concern) in order to (the primary perceived function of the behavior of concern)  |

|  |
| --- |
| **Replacement behavior 1: Describe the behavior that will be taught. Include how this behavior matches the function of the behavior of concern.**  |

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| --- |
| **Instructions and modifications designed for the Positive Behavior Support Plan** |
| **Antecedent (prevention) strategies:** |
|  **Replacement behavior:**  |
|  **Reinforcement for when the individual performs the replacement behavior:**  |
| **Goals and data gathering or analysis: Reduction and replacement goals are listed here. Include type of measurement and analysis.** |
|  |

| **Prioritized behaviors of concern for the current plan year**  |
| --- |
| **Behavior of concern 2: Operationally define the behavior.** |
| **Linked to the following guiding values:** |

|  |  |
| --- | --- |
| Antecedents/Triggers | Behavior |
|  |  |
| Maintaining Consequence | Why this Behavior Works |
|  |  |
| **Skills related to behavior of concern****Check the box that best reflects the individual’s skill level and describe the impact that strength or suggested areas of improvement may have on the plan.**  |
| **Skill Area** | **Effect on plan** |
| Cognitive skills | Strengths:Supports needed: |
| Communication | Strengths:Supports needed: |
| Coping skills | Strengths:Supports needed: |
| Social skills | Strengths:Supports needed: |

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| --- |
| **Hypothesis statement** |
| When (antecedents to the behavior of concern) the individual (behavior of concern) in order to (the primary perceived function of the behavior of concern)  |

|  |
| --- |
| **Replacement behavior 2: Describe the behavior that will be taught. Include how this behavior matches the function of the behavior of concern.** |

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| --- |
| **Instructions and modifications specially designed for the Positive Behavior Support Plan** |
| **Antecedent (prevention) strategies:** |
|  **Replacement behavior:**  |
|  **Reinforcement for when the person performs the replacement behavior:**  |
| **Goals and data gathering or analysis: Reduction and replacement goals are listed here. Including type of measurement and analysis.** |
|  |

| **Behaviors of concern prioritized for future plan:** *Rank in priority order the behaviors that will become part of the next functional assessment and positive behavior support plan. Monitoring of the current plan and these behaviors will help guide revision of this plan and future plans as data is gathered and evaluated.*  |
| --- |
| 1.
2.
3.
 |

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| --- | --- | --- |
| **Previously mastered replacement behaviors** | **Original FA/PBSP dated** | **Date removed**  |
|  |  |  |
|  |  |  |

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| --- |
| **De-escalation procedures**  |
| Behavior of concern | Action – Accommodation – Prompt |
|  |  |
|  |  |
|  |  |
| *Documentation* |
| What to count and document: |  |
| Where to send document: |  |
| **Crisis Response Procedures** |
| Behavior of concern | Action – Accommodation – Prompt |
|  |  |
|  |  |
|  |  |
| *Documentation* |
| What to count and document: |  |
| Where to send document: |  |

| **Restrictive procedures****A restrictive procedure may be used only for the purpose of protection.** **It must not be used for the purpose of changing behavior in situations where no need for protection is present.** |
| --- |
| **Restrictive procedures:** *Document anything that restricts an individual’s freedom of movement, restricts access to the individual’s property, requires the individual to do something which they do not want to do or removes something the individual owns or has earned. Restrictions could include medications, door alarms, altered diets, restraints (mechanical or physical) and other things. Refer to policy 5.15 or policy 5.20 for additional information.* |
| Restrictive procedure: | Justification for use of restrictive procedure: |
|  |  |
| **Criteria for reduction and elimination of restrictive procedures:** *This is the behavioral criteria that will “trigger” a reduction in the “restrictive procedure.” Note: This is not a criterion that will trigger a meeting but will trigger actual reduction or termination of the restriction.* |
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| --- | --- | --- |
| Author of report and title | Signature | Telephone or Email |
|  |  |  |
| Person supported by DDA | Signature | Signature date |
| ***By signing, I am agreeing with the following statements:****• I have been involved in the development of this plan.**• The plan has been explained to me.**• I agree to fully participate in this plan.* |  |  |
| Guardian | Signature | Signature date |
| ***By signing, I am agreeing with the following statements:***• *I have been involved in the development of this plan.**• The plan has been explained to me.**• I agree to this plan and will participate, when necessary, to ensure success for the individual receiving services.* |  |  |