



Behavior Treatment Plan Consent

IDENTIFYING INFORMATION				
NAME	DOB		CASE #	GENDER
ADDRESS				

DOCUMENT DATE

I consent to have null participate in a behavior plan in effect at:

I am aware the focus of this plan is to assist in learning alternatives to the identified behaviors that present risk of harm to self or others. I have been provided a copy of the program and have been given the opportunity to ask questions and provide input.

I understand the behaviors for which alternatives have been developed are:

I understand that the primary restrictions identified in the plan are as follows:

I understand that the risks of this plan may include:

I understand the potential benefits of this plan include:

I understand that the general approaches of this plan include:

(Medications if used are listed for informational purposes only)

I am aware that my consent is binding, but I may withdraw my consent. I understand that this plan will be reviewed for approval and monitoring by Community Mental Health & Substance Abuse Services of St. Joseph County Behavior Treatment Review Committee.



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- My signature indicates that I understand the above behavior treatment plan and that I am providing informed consent. I have given this consent without coercion.
- I withdraw my consent to this Behavior Treatment Plan.

Pursuant to MDHHS Administrative Rules, I offered further explanation regarding the content, purpose and proposed result of this treatment plan to

who indicated that he/she understands this consent form and the Behavior Treatment Plan it represents. This consent was freely and knowingly given. The authorized party was willing and able to grant this consent.

When the plan is updated, changed or renewed, informed consent will be obtained.

**SIGNATURES**

\_\_\_\_\_  
STAFF SIGNATURE / CREDENTIALS

\_\_\_\_\_  
DATE

\_\_\_\_\_  
CLIENT SIGNATURE

\_\_\_\_\_  
PRINTED NAME

\_\_\_\_\_  
DATE



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