

# The Network for Behavior Change, pc

Steven Kossor, Director

Federal EIN: 23-2967070

phone or fax

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*There are no obstacles, only hurdles of varying heights. None is so great that it cannot be overcome, gotten around or gone under. Even mountains disintegrate with time.*

## REPORT OF: Initial Bio-Psycho-Social Evaluation

### I. Identifying Information

**INITIAL AUTHORIZATION:** 11/11/1111

**NAME:** \*\*\*\*\*, \*\*\*\*\*

**Date:** 11/11/1111

**MA#:** 123456789

**SS#:** 123-45-6789

**Birthdate:** 11/11/1111

**Current Address:** \*\*\*\*\* \*\*\*\*\* PA \*\*\*\*\*

**Current School:** \*\*\*\*\* Area

**Grade:** 2

**Current Custody of Child:** Parents

**Phone:** \*\*\*-\*\*\*-\*\*\*\*

**Gender:** Male

**Race:** Caucasian

**Chronological Age:** 7-6

### II. Reason for Referral

\*\*\*\*\* was referred for initial evaluation of the appropriateness of beginning to provide Behavioral Health Rehabilitation (BHR) Services. It was felt that the results of the present evaluation represented an accurate sample of \*\*\*\*\*'s current strengths, weaknesses and needs, albeit based on a limited sample of \*\*\*\*\*'s behavior. It was anticipated that a more thorough evaluation, with a more explicit Treatment Plan, would be developed over the course of the anticipated authorization period. This evaluation reflects the Interagency Team Members' thinking regarding the recommended services for this child at this time.

### Assessment Techniques Used

Information Questionnaire

Medical Resume Questionnaire

Devereux Scales of Mental Disorders (DSMD) - Child form

Clinical interview with \*\*\*\*\*

Interview with parent \*\*\*\*\*

Interview with school officials

Teacher \*\*\*\*\*

Principal \*\*\*\*\*

School Psychologist \*\*\*\*\*

Special Education Coordinator \*\*\*\*\*

Review of Records

### III. Relevant Information

#### Strengths

\*\*\*\*\* was a cheerful, responsive and polite young man who readily interacted with the examiner in a congenial and age-appropriate fashion. He showed appropriate reluctance to discuss his apparently frequent involvement in finger nail-biting, but did not appear to

be traumatized by the examiner's focus on this, or other unflattering aspects of his behavior (especially in school, which included a significant history of impulsively aggressive outbursts against peers). \*\*\*\*\* was responsive to his mother's prompts, appeared to seek appreciation and recognition from her, and was able to wait patiently in an anteroom, occupied with a hand-held electronic game (via his mother's cellular telephone) while his mother met privately with the examiner for thirty minutes. Unbeknownst to him, he was observed continuously through a window during the time that his mother was absent from the room and did not misuse the telephone or take advantage of the apparent lapse in adult supervision. He reportedly did exceptionally well in math, has played soccer for five seasons at the local YMCA, plays little league baseball, and has been taking Tai Kwon Do lessons at a local dojo for the past year. He indicated that he liked building projects with Leggo<sup>®</sup> blocks, magnets and building things in his father's woodshop.

### **Needs & Concerns** (behavioral difficulties and/or mental health symptoms)

\*\*\*\*\*'s mother indicated that he had great difficulty with impulse control, problem-solving, and aggressive behavior. He was reportedly very physical in his play with others, tended to assume authoritarian roles with playmates, and perceived insults when none had occurred. He behaved disrespectfully and argumentatively toward adults, including his parents (albeit less-so with his father). He showed excessive criticism of his peers (seemingly oblivious to the chilling effect that this behavior had on his ability to make and sustain friendships). \*\*\*\*\* had difficulty inhibiting his angry responses when his wishes were thwarted. He often refused to accept responsibility for his misbehavior or failure. He appeared to crave a high degree of recognition and appreciation from adults, but when he was unable to experience adequate satisfaction of this craving, he was prone to displaying behavior that was inherently self-defeating.

\*\*\*\*\* reluctantly admitted to having been involved in several aggression incidents at school, but he tended to minimize these. His mother reported that he had been sanctioned by school authorities for having pushed and fought with peers on several occasions, that he frequently related in a belligerent and defiant manner toward any adult who set limits on him, and that he often made unnecessarily provocative, abusive comments to peers (that provoked them to behave aggressively toward him). \*\*\*\*\* appeared to have exceptionally low tolerance for misbehavior of his peers, and complained that his teacher and other adults failed to discipline peers who misbehaved. Overall, \*\*\*\*\* functioned as though he was younger than his chronological age; his mother reported that he preferred to play with younger peers, and that he socialized more like four and five year-old children of her acquaintance.

### **Summary of family resources, strengths and barriers to treatment**

\*\*\*\*\* lived in an intact family with father, \*\*\*\*\*, his mother, \*\*\*\*\*, and his three year-old brother, \*\*\*\*\*. His father was employed as a landscape contractor and his mother was not employed outside of the home at this time, although she had formerly worked as a Case Manager in the human services field. Both parents were involved and supportive

of \*\*\*\*\*'s needs, with \*\*\*\*\*'s mother having the lead role in addressing his treatment and school needs.

### **Community resources, safety issues, peer group, cultural and related issues**

\*\*\*\*\* reportedly lived in a safe neighborhood, but he was too young to venture from his home unaccompanied. He has participated in group sports for several years, but has shown persistent involvement in behavior that has alienated him from peers in a variety of social contexts. He has not been involved in church or other regularly scheduled social activities, although he did report having friends in the neighborhood.

### **Comprehensive Histories**

#### **Psychological-Psychiatric History** (*includes inpatient, outpatient and past treatment involvement*):

Owing to his young age, \*\*\*\*\* has not been involved in psychological counseling, although he has been involved in the developmental program at \*\*\*\*\* since the age of 4, when he began taking Ritalin. His paternal great-grandmother was reportedly diagnosed as bi-polar. A paternal great aunt was reportedly enrolled at the \*\*\*\*\* School; \*\*\*\*\*'s mother indicated that she had displayed symptoms of schizotypal personality disorder. \*\*\*\*\*'s maternal great-grandmother was reportedly hospitalized for psychosis following the birth of her third child, but reportedly also had episodes of paranoia throughout her life. A maternal cousin (age 15) was reportedly also diagnosed with bi-polar disorder. A paternal cousin was described as having ADHD.

#### **Emotional Functioning History** (*history of emotional stability and response to stressors*):

\*\*\*\*\* has had a lengthy history of showing rapid anger, impulsive outbursts, excessive perception of injustice perpetrated by others against himself, and unnecessarily aggressive responses (verbally and physically) to peers. These symptoms have persisted despite an active treatment program involving medication and behavioral interventions that have been implemented with little success at home and in school. \*\*\*\*\*'s behavior has reportedly been characterized recently by his teacher as "dangerous" and the school has indicated to his mother that \*\*\*\*\*'s needs might better be met through placement at the \*\*\*\*\* Center, a partial hospitalization program, or an Approved Private School placement. It is noted that \*\*\*\*\*'s mother objects to these suggestions, noting that they appear to be premature (in that no significant behavioral intervention program has yet been implemented in the school).

#### **Educational History & School Behavior Concerns** (*achievement, behavior & Special Ed needs*):

\*\*\*\*\*'s IEP was in the process of development at this writing. He has been evaluated by the school psychologist, and the report is in press. \*\*\*\*\*'s former IEP from the Collegium Charter School was reviewed and indicated that he met the criteria for a child in need of special education services, but that he had less than 21% of need for placement outside of regular classes. His IOWA tests indicated that he was at or above the average range overall, with particular strengths noted in the area of mathematics. The Notice of

Recommended Educational Placement dated 11/11/1111 from the \*\*\*\*\* Charter School indicated a plan for \*\*\*\*\* to receive Speech Therapy within the context of a regular education program, following improvement in his academic achievement. \*\*\*\*\* also recently received Occupational Therapy services; the therapist was reportedly recommending a more thorough evaluation on account of the discovery of significant deficits. \*\*\*\*\* left the \*\*\*\*\* Charter School at the end of the past academic year, due to parental concerns over the reduced academic opportunities that they perceived for their son at that location. At the present time, \*\*\*\*\*'s school (\*\*\*\*\* Elementary School in the \*\*\*\*\* Area School District) was recommending an alternative education placement due to \*\*\*\*\*'s display of aggressive and potentially harmful behavior toward others. This was felt to be premature, inasmuch as no evidence for the conscientious implementation of a Behavioral Health Rehabilitation (BHR) Service program was apparent, which appeared to have substantial potential for facilitating \*\*\*\*\*'s remaining in the public school, regular education setting.

**Spiritual History** (*involvement in religious practices and any available church-related supports*):

No significant events in this domain were reported. \*\*\*\*\*'s mother indicated that \*\*\*\*\* had experienced several incidents of agitation during Sunday School in the past and that he showed no interest in returning to that program at the present time.

**Aggression & Suicidality History** (*suicidal behavior, ideation, and history of aggression, if any*):

According to his mother, \*\*\*\*\* has not exhibited suicidal behavior. He was reportedly very cautious regarding his own safety. As a toddler, \*\*\*\*\* reportedly bit others without provocation, and throughout his development, his mother indicated that he has injured other children in the past due to impulsive, unprovoked and unpredictable tantrum behavior outbursts. However, she noted that his current aggressive outbursts were reliably displayed in response to frustration experiences.

**Maturational History** (*summarize development, prenatal concerns & developmental delays, if any*):

\*\*\*\*\*'s prenatal history was reportedly unremarkable. He was born full-term via C-section and weighed 8 pounds, six ounces at birth. He reportedly had many ear infections prior to the age of 1, leading to a tympanostomy with myringotomy at the age of 18 months. \*\*\*\*\* reportedly had an 80% hearing loss in one ear prior to these surgical interventions. All other developmental milestones were reportedly within normal limits.

**Nutritional History** (*dietary concerns and general physical fitness*):

\*\*\*\*\* was typically in the 95<sup>th</sup> percentile for height and at the 75<sup>th</sup> percentile for weight until the age of 3, when he gained a great deal of weight. He is an extremely fussy eater, however, and was unwilling to try unusual foods. He was overweight at the present time, although he has shown some reduction in his curve for weight gain in the past two years.

**Vocational History** (*involvement in paid work activities, if any*):

No vocational activity was performed. \*\*\*\*\* was reluctant to respond to his mother's requests to complete assigned tasks around the house. He was somewhat more responsive to his father's prompts, but he characteristically sought to negotiate whenever any adult placed a performance expectation before him.

**Legal History** (*legal circumstances relevant to treatment, such as custody*):

Although the \*\*\*\*\* Area School District appeared to have recommended alternative education placement options prematurely, \*\*\*\*\*'s mother did not indicate an intention to pursue legal action against the school district apart from advocating strongly on behalf of \*\*\*\*\* at the Individual Education Plan meeting scheduled shortly.

**Sexual History** (*history of sexual abuse victimization, perpetration, or sexual experience base*):

No indications of sexual misconduct or abuse were noted in this evaluation.

**Substance Abuse History** (*including eating or mouthing of inedible objects*):

No indications of substance abuse, or eating inedibles, were noted in this evaluation.

**Medical Intervention & Developmental History**

The following is a summary of the child's medical intervention history, including medication usage, hospitalizations, and other significant medical treatments and events.

- **Current medical status**

\*\*\*\*\* was observed in his home, interacting with his mother. He appeared to relate positively to his mother, and did not show evidence of any thought disorder. On one occasion, his mother challenged him and he responded readily by appealing for her to refrain from further description of his problematic behavior, but he did this in a peculiar way – he moved his head closer to his mother's body, and spoke to her in an admonishing tone while he fixed his gaze unblinkingly at a point somewhere beyond his mother. Thus, it appeared that \*\*\*\*\* had become accustomed to responding in a detached manner to authority figures who set limits on him.

\*\*\*\*\* showed no gross signs of physical or cognitive disability, and occupied himself quietly and appropriately for about 30 minutes while his mother met with the examiner in an adjacent room (while maintaining discrete observation of \*\*\*\*\* throughout). It was noted that \*\*\*\*\* played appropriately with the video game on his mother's cellular telephone, but showed no interest in the children's magazine that was offered to him. His mother indicated that his preference for after-school activities did not include reading. He appeared to be bright, motivated to interact with the examiner when questioned, and showed remarkable ability to wait patiently for his mother to finish her conversations before interjecting his thoughts. He

appeared to have a sense of humor and playfully engaged the examiner in some verbal repartee as he was leaving the office. His mother indicated that several friends and acquaintances had remarked on \*\*\*\*\*'s potential for becoming a lawyer someday.

- **Medication History, indications and dosages received**

Medication Name	Daily Dose	Prescribing Physician	Reason Prescribed & Start Date (Stop Date, if applicable)
Metadate	60 mg. AM	***** , MD	10/15/2002
Ritalin	35 mgs/day	Same as above	1/1/2002
Prozac	4 mg/day	Same as above	6/1/02
Concerta		Same as above	10/01 to 10/02
Tenex			10/01 to 7/02
Dexedrine			2 weeks only in 2000

\*\*\*\*\* was first diagnosed with ADHD and placed on psychotropic medication at the age of four years. \*\*\*\*\* was expected to begin a trial on Wellbutrin in December, to replace treatment with Prozac which was initiated to reduce his responsivity to peer provocation and other frustration.

- **Allergies & Sensitivities**

No allergies to foods, drugs or environmental stimuli were reported by his mother.

### Services and Service Update

- **Non-BHR Services used in past, reason and effectiveness**

\*\*\*\*\* received instruction in the 1-2-3 Magic cognitive behavioral intervention program at school and this was not felt to have been effective for him. Similarly, time-out periods had not proven successful to date. The removal of privileges was practiced as a disciplinary procedure at home and at school, with little success. \*\*\*\*\*'s parents were well-aware of the potential value of scheduled tangible reinforcement, but noted with dismay that their son did not seem to appreciate rewards as much as other children his age.

- **Summary of past BHR Services Progress**

\*\*\*\*\* had been referred to the Network for Behavior Change for evaluation of the need to deliver BHR Services on 11/11/1111. No BHR services had yet been delivered to \*\*\*\*\*. It was felt that the target behavior depicted in the table on the following page should be addressed with \*\*\*\*\* at the present time.

<b>Target behavior</b>
physical aggression against peers
confrontational and defiant behavior toward adults
refusal to accept age-appropriate performance expectations

- **Current services**

Speech therapy and Occupational Therapy services were currently being delivered. No BHR Services had been attempted previously with \*\*\*\*\*.

- **Noteworthy Effective Interventions**

\*\*\*\*\*'s mother indicated with exasperation, that she had been unable to discover any single intervention modality that reliably worked successfully for \*\*\*\*\*. He had responded to parental prompts in a negative and excessively argumentative way on many occasions, and found-fault with his parents' disciplinary responses to his younger brother as well.

- **Noteworthy Ineffective Interventions**

\*\*\*\*\*'s mother indicated that she was not aware of any discipline practice that was reliably ineffective with \*\*\*\*\*.

- **Known barriers to Treatment**

\*\*\*\*\*'s family appeared to be intact, without significant financial stressors, and he appeared to have access to an adequate supply of potential playmates. His mother, especially, appeared to be highly motivated to assist him in receiving therapeutic interventions as quickly as possible.

- **Planned modifications of goals and Services**

Previous interventions have proven insufficient, and BHR Services have been requested as the least-restrictive and least-intrusive elements in the continuum of outpatient psychological services at this time. \*\*\*\*\* does not require inpatient psychiatric or psychological treatment, or residential educational placement at this time, although the latter had reportedly been considered by \*\*\*\*\* Area School District officials in their communication with \*\*\*\*\*'s mother prior to her referral of her son to The Network for Behavior Change.

### **Summary of discharge planning**

The plan was to discontinue BHR Services in the least amount of time possible in which to enable \*\*\*\*\* to attain and generalize behavioral goals. Discharge should occur when the average of teacher frequency and severity ratings of the target behavior described in the table on the following page reach the indicated levels.

Target behavior	Discharge Criteria
physical aggression against peers	4 for two consecutive weeks
confrontational and defiant behavior toward adults	4 for two consecutive weeks
refusal to accept age-appropriate performance expectations	4 for two consecutive weeks

### Summary of efforts to promote cultural competence

Neither \*\*\*\*\* nor his family has expressed any preference for the racial, ethnic or cultural background of the professionals who would provide services to him and no conflicts in this area are anticipated. The Child and Adolescent Service System Program (CASSP) principles will serve as a global guide to treatment. All professionals involved in providing services to \*\*\*\*\* will be attentive to issues of culture, race or ethnicity and will address any such concerns professionally and forthrightly.

### IV. Mental Status Evaluation

\*\*\*\*\* was reportedly able to differentiate right from wrong and his mother felt that he was unlikely to be victimized by designing persons. She noted that diagnostic testing in the past had suggested the existence of an auditory processing deficit that was scheduled to be further evaluated in the near future. \*\*\*\*\* was not presenting as a depressed child, although his interaction patterns with peers was decidedly less consistent than most children his age. Although he generally appeared to his mother to be happy, some indices of anxiety were noted in his extremely bitten-down fingernails, heightened irritability and hypersensitivity to perceived injustice. His mother indicated that he consistently displayed a “larger than life” response to situations – either more enthusiastic or more annoyed than would be typical for a child his age.

\*\*\*\*\*’s mother noted that he had little apparent control over his primary impulses, and had negligible tolerance for frustration. He was described as “*knowing what to do, but never doing what he knows he should do.*” His mother indicated that \*\*\*\*\* sought the company of others, but generally he behaved in a bossy or “in charge” way with peers, which led them to distance themselves from him on many occasions. \*\*\*\*\* seemed to have some difficulty with fine-motor coordination, and was expected to receive recommendations for improvement in motor functioning via the anticipated OT consult. Periodic consultations with the prescribing practitioner who had ordered \*\*\*\*\*’s psychotropic medication would be continued.

### Adaptive and Social Functioning Assessment

Analysis of \*\*\*\*\*’s adaptive and social functioning was facilitated through the administration of the *Devereux Scales of Mental Disorders (DSMD) for Children*, completed by \*\*\*\*\*’s mother on 11/11/1111. When compared with other children of similar age, \*\*\*\*\* was found to display a variety of aberrant behavior patterns. He was reported by his mother to be frequently involved in annoying others, behaving disruptively and getting in trouble during playtime, appearing unaware of others’ responses to his behavior, acting bossily toward peers, becoming easily upset by others’ provocative speech toward him, and behaving in an excessively irritable manner. \*\*\*\*\*

reportedly showed little self-control over his impulses and readily confronted adults and peers whenever his wishes were thwarted. He tended to sulk or pout when the gratification of his needs was postponed, had trouble concentrating, and easily became overexcited by relatively innocuous events.

## V. Discussion

- **Overview/summary**

\*\*\*\*\* has displayed significant developmental delays in socialization skill acquisition for some time, and has behaved in a provocative, excessively volatile and aggressive manner toward peers in school, resulting in his reportedly being identified as a child who was potentially dangerous to his peers. He had been receiving treatment consultations since the age of four to address these chronic behavioral challenges, with minimal success. His mother appeared to be a conscientious and effective advocate for him, but was identifying needs for emotional and behavioral treatment that eclipsed her ability to respond to, without professional intervention (especially at school). \*\*\*\*\* has shown some evidence of a neurosensory auditory processing deficit and this was to be evaluated in the near future. In conjunction with conscientious efforts by physicians at the \*\*\*\*\* Hospital, it was felt that \*\*\*\*\* required intensive outpatient treatment at this time (BHR Services), in order to deter him from injuring others, avoid the possibility of a more restrictive educational placement, and to improve his ability to socialize with peers and adults at an age-appropriate level.

- **Hypothesis/formulation**

\*\*\*\*\* appears to have experienced some level of neurosensory impairment for some time and his recent referral to a pediatric neurologist was greeted with hopeful expectations for achieving greater clarity in uncovering the etiology of his condition. He appears to have some difficulty with fine-motor skills and an Occupational Therapy evaluation is anticipated in the near future. The combination of attentional deficits, frequent complaints of gastrointestinal distress, and joint pain suggest that \*\*\*\*\* should have been referred for evaluation to rule-out Lyme disease, and this was presently underway. It appears that \*\*\*\*\*'s adoption of a characteristically "bossy" or over-controlling attitude with peers may be a manifestation of his underlying deep desire to be recognized and appreciated as a "good" child; his experience of significant difficulty in socializing at school appears to have resulted in his choosing to avoid social contact with peers as a defense against failure in social situations, and he prefers to interact with adults.

- **Rationale for recommended services**

\*\*\*\*\* has shown a pattern of chronic, severe, and escalating involvement in maladaptive behavior, including behavior that presented a danger to himself and others, and BHR Services are a necessary intervention for \*\*\*\*\* at this time, to avert continued necessity for the prescription of psychotropic medication, to eliminate the potential for residential education placement, and to minimize the probability that he will require inpatient hospitalization due to the display of aggressive and regressed behavior.

- **Consensus and agreements with child and caregivers**

\*\*\*\*\*'s parents were in agreement that he needed professional mental health services at this time. School officials concurred in this assessment, inasmuch as \*\*\*\*\* had been considered a candidate for Approved Private School placement or enrollment at the \*\*\*\*\* Center due to his having presented dangerous behavior in the classroom recently. It would clearly be inappropriate to remove \*\*\*\*\* from his present educational placement without having first implemented a Behavioral Health Rehabilitation (BHR) Service delivery program consisting of TSS and Behavior Specialist providers who were actively striving to integrate home and school behavior management approaches.

- **Prognosis:** Guarded, considering the chronicity and severity of \*\*\*\*\*'s behavioral difficulties, but this is mitigated to some extent by his cheerful and outgoing personality traits.

## VI. DSM IV diagnoses

**AXIS I:** ADHD, Impulsive Type

**AXIS II:** No diagnosis on Axis II

**AXIS III:** Rule-out auditory processing deficit & speech disorder

**AXIS IV:** Chronic pattern of oppositional behavior toward adults, developmental delays in socialization skills, history of exaggerated responses to stimuli.

**AXIS V: Past: 45 Now: 45**

## VII. Recommendations

### *Outpatient Mental Health Services*

1. The results of this evaluation indicate that \*\*\*\*\* clearly requires professional mental health services at this time, in order to reduce the probability that he will require more restrictive interventions and/or long-term psychiatric treatment and behavioral intervention in the future. As defined by Pennsylvania Department of Public Welfare and Office of Mental Health and Substance Abuse Services standards, these services are considered to be medically necessary for \*\*\*\*\* at this time.
2. It is recommended that BHRS Therapeutic Staff Support services (25 hours per week at school) should be provided to \*\*\*\*\* in conjunction with Behavior Specialist Consultations (Masters level, 3 hours per week) involving \*\*\*\*\* and his teachers at his school and his parents at home to assist \*\*\*\*\*'s teachers and parents in implementing behavior change strategies correctly and consistently both at home and in school. The reader is referred to the most recently created Treatment Plan, of which this writer was a contributing author, for relevant additional information concerning specific goals, objectives, implementation strategies and time frames.

*Special Education Services*

3. The results of this evaluation indicate that \*\*\*\*\* meets the classification criteria for a child in need of special education services due to his display of mental illness symptoms, and indicate his need for an intensive individualized education program of instruction delivered in a highly structured, supportive milieu.

*School-Related Recommendations*

4. Completion of Occupational Therapy and Speech evaluations to further elucidate the nature of \*\*\*\*\*'s deficits and receipt of these professionals' reports so that their recommendations can be incorporated into the BHRS treatment planning process.

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Steven Kossor Date  
Director, *The Network for Behavior Change*  
MA Provider #: 1710770  
Licensed Psychologist #: PS-003680-L  
Certified School Psychologist

# The Network for Behavior Change, pc

Steven Kossor, Director

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## BHRS TREATMENT PLAN

INITIAL: 11/11/1111

Name: \*\*\*\*\* , \*\*\*\*\*

SS#: 123-45-6789

Address: \*\*\*\*\* , PA \*\*\*\*\*

MA#: 123456789

Date of Meeting: \_\_\_\_\_

DOB: 11/11/1111

Custody: Parents

Phone: \*\*\*-\*\*\*-\*\*\*\*

Next Meeting: 11/11/1111

### Indicate Type of Plan

Behavioral Specialist Consultant  
 Mobile Therapist  
 TSS

### Indicate Cycle of Plan

Initial Treatment Plan  
 Treatment Plan Review

## DIAGNOSES

<b>AXIS I:</b>	ADHD, Impulsive Type
<b>AXIS II:</b>	No diagnosis on Axis II
<b>AXIS III:</b>	Rule-Out auditory processing deficit & speech disorder.
<b>AXIS IV:</b>	Chronic pattern of oppositional behavior toward adults, developmental delays in socialization skills, history of exaggerated responses to stimuli.
<b>AXIS V:</b>	<b>Past:</b> 45 <b>Now:</b> 45

**STRENGTHS:** \*\*\*\*\* was a cheerful, responsive and polite young man who readily interacted with the examiner in a congenial and age-appropriate fashion. He showed appropriate reluctance to discuss his apparently frequent involvement in finger nail-biting, but did not appear to be traumatized by the examiner's focus on this, or other unflattering aspects of his behavior (especially in school, which included a significant history of impulsively aggressive outbursts against peers). \*\*\*\*\* was responsive to his mother's prompts, appeared to seek appreciation and recognition from her, and was able to wait patiently in an anteroom, occupied with a hand-held electronic game (via his mother's cellular telephone) while his mother met privately with the examiner for thirty minutes. Unbeknownst to him, he was observed continuously through a window during the time that his mother was absent from the room and did not misuse the telephone or take advantage of the apparent lapse in adult supervision. He reportedly did exceptionally well in math, has played soccer for five seasons at the local YMCA, plays little league baseball, and has been taking Tai Kwon Do lessons at a local dojo for the past year. He indicated that he liked building projects with Leggo<sup>®</sup> blocks, magnets and building things in his father's woodshop.

## CURRENT MEDICATIONS AND DOSAGES:

Medication Name	Daily Dose	Prescribing Physician	Start Date
Metadate	60 mg. AM	*****, MD	10/15/2007
Ritalin	35 mgs/day	Same as above	1/1/2007
Prozac	4 mg/day	Same as above	6/1/2007



# Behavior Record Form

**Child's Name:** \*\*\*\*\*, \*\*\*\*\*

**MA ID #:** 123456789

**Goal #1:** Increase tolerance for frustration from peers & eliminate aggression

**Goal #2:** Increase tolerance for frustration from adults & eliminate defiant responses

**Goal #3:** Increase tolerance for age-appropriate performance expectations

Once each **week** record the teacher's ratings about frequency and severity of the target behavior below. Write notes about the child's behavior on the back of this form any time so that, when the Licensed Psychologist meets with you (at least once weekly) to supervise your work, you can cover all of the issues that you are concerned about for this child.

Frequency scale: *Failure* to meet goal ranges from very rarely (1) to *extremely* frequently (10)  
 Severity scale: Severity of behavior ranges from very low (1) to *extremely* difficult to manage (10)

Date	Target Behavior Description	Frequency	Severity
	Target 1: physical aggression against peers		
	Target 2: confrontational and defiant behavior toward adults		
	Target 3: refusal to accept age-appropriate performance expectations		
	Target 1: physical aggression against peers		
	Target 2: confrontational and defiant behavior toward adults		
	Target 3: refusal to accept age-appropriate performance expectations		
	Target 1: physical aggression against peers		
	Target 2: confrontational and defiant behavior toward adults		
	Target 3: refusal to accept age-appropriate performance expectations		
	Target 1: physical aggression against peers		
	Target 2: confrontational and defiant behavior toward adults		
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	Target 3: refusal to accept age-appropriate performance expectations		

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## BHRS PLAN OF CARE – SUMMARY

**INITIAL:** 11/11/1111

**NAME:** \*\*\*\*\*, \*\*\*\*\*      **DOB:** 11/11/1111      **TIME PERIOD:** 11/11/1111 to 11/11/1111  
**MA #:** 123456789      **SS#:** 123-45-6789      **AUTHORIZING AGENTS:** \_\_\_\_\_  
**School District:** \*\*\*\*\* Area      **Provider Name:**      *The Network for Behavior Change*  
**Race:** Caucasian      **Sex:** Male      **Provider 41 Agency:** *The Network for Behavior Change* MA ID#: 1710770

- AXIS I:**      ADHD, Impulsive Type
- AXIS II:**      No diagnosis on Axis II
- AXIS III:**      Rule-Out auditory processing deficit & speech disorder.
- AXIS IV:**      Chronic pattern of oppositional behavior toward adults, developmental delays in socialization skills, history of exaggerated responses to stimuli.
- AXIS V:**      **Past:** 45      **Now:** 45

SERVICES	SERVICE PROVIDER	RESPONSIBLE PERSON	LENGTH OF SERVICES	FREQUENCY	FUNDING SOURCE	COST PER UNIT	TOTAL COST*
Behavior Specialist (unlicensed)	<i>The Network for Behavior Change</i>	*****	4 Months (until 11/11/1111)	3 hrs/wk	MA	\$12.50 per ¼ hour unit	\$2,565
Therapeutic Staff Support	Same as above	*****	Same as above	25 hrs/wk	MA	\$15 per ½ hour unit	\$12,875
Psychological Re-evaluation	Same as above	*****	3 hours	3 hours total	MA	\$26.25 per ½ hour unit	\$157.50
Education services	***** Area School District	*****	Ongoing	Ongoing	*****		610-***-****

\*Total Cost is based on 17.1 weeks in the proposed authorization period.

BHRS

Review Date: 11/11/1111

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## BHRS TREATMENT PLAN

**Member's Name:**      \*\*\*\*\* , \*\*\*\*\*

**S.S.N.:**                123-45-6789

**Facility:**            *The Network for Behavior Change*

**Phone #:**            610-383-1432

**INITIAL:** 11/11/1111

**Date(s) of service:** 11/11/1111 to 11/11/1111

**Authorization #:** \_\_\_\_\_

**Member's DOB:** 11/11/1111

**Member's MA ID#:** 123456789

**TARGET PROBLEM BEHAVIOR(S) / NEED:** physical aggression against peers, confrontational and defiant behavior toward adults, refusal to accept age-appropriate performance expectations

Long Term Goal	Objective(s)	Method(s) of achieving objective	Service type & location of services	Estimated time frame	Frequency of service per week
1. Increase tolerance for frustration from peers & eliminate aggression	1. Reduce or eliminate physical aggression against peers.	TSS will utilize behavioral rehearsal, modeling, role-playing, prompting, and contingency contracting to shape new skills. BSC will monitor program, train staff, and make necessary amendments to Plan and will facilitate collaboration between medical, behavioral, educational and home & community domains. The average of teacher frequency and severity ratings of physical aggression against peers will be below 4 for two consecutive weeks by 11/11/1111.	TSS at school  BSC (Masters level)	4 months  4 months	25 hours per week  3 hours per week
2. Increase tolerance for frustration from adults & eliminate defiant responses	2. Reduce or eliminate confrontational and defiant behavior toward adults.	As above. The average of teacher frequency and severity ratings of confrontational and defiant behavior toward adults will be below 4 for two consecutive weeks by 11/11/1111.	As above.	As above.	As above.
3. Increase tolerance for age-appropriate performance expectations	3. Reduce or eliminate refusal to accept age-appropriate performance expectations.	As above. The average of teacher frequency and severity ratings of refusal to accept age-appropriate performance expectations will be below 4 for two consecutive weeks by 11/11/1111.	As above.	As above.	As above.

<p>Crisis/Emergency Plan</p>	<p>Reduce or eliminate the probability of serious injury to the client or others.</p>	<p>In the event of a life-threatening emergency, a caretaker or any staff member will call 911. Efforts will be made to prevent the child from injuring himself or herself, or others. The licensed psychologist who provides supervision to BHR service providers will be contacted. The psychologist will facilitate and assist in the completion of an emergency mental status evaluation, including consultation with a psychiatrist. In the absence of a psychiatric consultation, the child will be transported to the nearest hospital emergency room for a physician's evaluation. The Managed Care Organization funding the child's treatment shall be contacted and, if an Intensive Case Manager is involved, that person will also be contacted. Appropriate notification of County Children and Youth authorities will be made. In a non-life-threatening mental health emergency, the child's Behavior Specialist and the licensed psychologist providing supervision to the child's BHR service providers will provide direct intervention and consultation to the child and any adult caretakers involved in the crisis.</p>			
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Signatures appear on attached page.



**BEHAVIOR PLAN OF TSS UTILIZATION**

TIME (BY HOURS)	TARGET BEHAVIOR	TREATMENT INTERVENTION	WHO WILL BE PRESENT FOR INTERVENTION?	EXPECTED OUTCOMES/ GOALS MET?
10:00 – 3:00 M-F @ school	***** will reduce or eliminate physical aggression against peers. Critical level to be achieved (on a scale from 1 to 10) is 4.	TSS will utilize behavioral rehearsal, modeling, role-playing, prompting, social stories and contingency contracting to shape new skills.  BSC will monitor program, provide oversight to TSS by observing service delivery and consulting as necessary to improve efficacy of service delivery, will amend interventions as necessary, and will train TSS provider as needed. BSC will also facilitate collaboration between funding agency, home, school, community agencies, and medical authorities as necessary.	***** , TSS	See formal Treatment Plan for additional details; the average of teacher ratings of frequency and severity for each Target Behavior specified at left will be below the critical level specified for at least two consecutive weeks, by the end of the treatment period (11/11/1111).
			***** , teacher	
	***** will reduce or eliminate confrontational and defiant behavior toward adults. Critical level to be achieved (on a scale from 1 to 10) is 4.		***** , BSC	
	***** will reduce or eliminate refusal to accept age-appropriate performance expectations. Critical level to be achieved (on a scale from 1 to 10) is 4.			
25 total TSS hours per week at school				

Child's Name: \*\*\*\*\* , \*\*\*\*\*

Clinician/ BSC SIGNATURE: (Master's or Doctoral Level): \_\_\_\_\_

Date: \_\_\_\_\_



Contact Record Form      DATE RECEIVED:  
**The Institute for Behavior Change, Inc**

**MA ID#:** 123456789

**SS #:** 123-45-6789

**DOB:** 11/11/1111

**CURRENT DSM IV Axis I diagnosis code:** \_\_\_\_\_

**CLIENT'S NAME:** \*\*\*\*\* , \*\*\*\*\*

**PHONE:** \*\*\*-\*\*\*-\*\*\*\*

<b>TSS Started:</b> 11/11/1111	<b>BS Started:</b> 11/11/1111	<b>MT Started:</b> 11/11/1111	<b>PSY Started:</b> 11/11/1111
<b>TSS Expires:</b> 11/11/1111	<b>BS Expires:</b> 11/11/1111	<b>MT Expires:</b> 11/11/1111	<b>PSY Expires:</b> 11/11/1111

BSM       BSD

<i>DO NOT USE THIS FORM AFTER</i> 11/11/1111				Typical Weekly Hours			<b>Date Transmitted:</b>						
Service Date	Start Time	Stop Time	EVAL	25			3			Amount Billed	Recipient Signature	Amount Paid	Date Paid
				TS	BS	MT	Trans.						

- 1 Family declines some (Or all) services      2 Family or child ill, or unavailable      3 Family prefers a different provider      8 Unsafe setting
- 4 Staff unavailable, family will wait      Other (explain below)

**Total Hours Billed** \_\_\_\_\_ = **Total Amount Billed** \_\_\_\_\_

Notes

My signature certifies that I have delivered the services or items listed above. I understand that payment for these services or items will be from federal and state funds, and that any false claims, statements, documents, or concealment of material may be prosecuted under applicable federal and state laws.

Provider's Signature: \_\_\_\_\_ Phone: \_\_\_\_\_

Editor's Note:

The forms in this document have been revised and updated since 2007 and are presented here for demonstration purposes only; forms currently in use comply 100% with all federal and state standards.

Following the Contact Record Form in this sequence of documents are the data collection forms for the TSS provider, fully integrated with the Treatment Plan, Plan of Care, and Psychological Evaluation Report. The child's assigned Behavior Specialist Consultant and the Licensed Psychologist supervising the case produce all of these documents to assure maximum continuity. Since these forms are highly customized to reflect the specific characteristics of the child receiving services, it was not practical to create an "anonymous" version. In addition, the TSS documentation forms approved for use in Philadelphia differ substantially from those approved for use by Managed Care Organizations elsewhere, so it would be equally confusing to display both forms, or to display just one form that may not seem familiar to the individual reader. Sample copies of TSS documentation forms are available for review upon request by contacting the Institute for Behavior Change.