ASSISTED INDEPENDENCE, LLC.
www.assistedindependence.care P.O. Box 1683 Columbus, IN 47202 812-374-9450

HIPAA Name: _____ CTRS Staff Name (Print): _____

Behavior Consultant Name (Print): _____

BSP Start Date: _____ Date Training Completed: _____

Please Identify the person's Diagnosis:

1.	2.	3.

Please identify Target Behaviors	Please identify Replacement Behaviors
1.	1.
2.	2.
3.	3.
4.	4.

Proactive Strategy

1.	4.
2.	5.
3.	6.

Reactive strategy

1.	4.
2.	5.
3.	6.

What is the function of the individuals' behaviors?

_____

List of psychotropic medications individual is taking:

_____

☐ I completed this training with the individuals Behavioral Consultant.

☐ I completed this training independently by reviewing the Behavior Support Plan provided by the Behavior Consultant to the BDDS Portal.

CTRS Signature: _____