**SANILAC COUNTY COMMUNITY MENTAL HEALTH**

**INFORMED CONSENT FOR USE OF BEHAVIORAL TREATMENT PLAN**

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

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Case #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for Use of Behavior Plan and Expected Benefits:

* Risk of harm to self-others
* Significant financial cost as a result of behavior (i.e. property destruction, fraudulent credit card use)
* Health & safety risks (i.e. refusals to take medications, attend medical appointments, eat meals, take liquids, toileting/hygiene after soiling self/clothes)
* Prevent illegal behaviors

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I understand that the Interdisciplinary Team recommends that the Behavior Plan be followed by my caregivers. The risks and benefits of the plan have been explained to my satisfaction, and I have received a copy of the Plan. Further, I understand the Behavior Treatment Committee will be approving or disapproving my plan if it proposes to use restrictive or intrusive methods and will review the use of psychoactive medications for any individual with a Developmental Disability. The Committee will also review when prescribed medications are used for behavior control purposes where the target behavior is not due to an active psychotic process. I understand and consent to this review being done by the Psychiatrist, Psychologist, Rights Officer, Clinical Supervisor, a Peer Support Advocate and my Supports Coordinator/Case Manager.

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 Signature Date

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 Primary Case Holder Signature Date

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 Guardian or Parent (if minor) Signature Date