ARIZONA DEPARTMENT OF ECONOMIC SECURITY Division of Developmental Disabilities

TEAM AGREEMENT OF BEHAVIOR TREATMENT PLAN

Name:		Date of Plan:	Date of Plan:	
Residence:				
Plan Developed By:		Date:		
APPROVAL SIGNATURES				
I have read and approved the use of the attached behavior plan.				
Responsible Person: D		Date:	e:	
Support Coordinator:		Date:	Date:	
Person Receiving Services:		Date:	Date:	
(Applicable for adults who have court appointed guardian)				
Residential Representative: Da		Date:		
Day/Work Representative:		Date:	Date:	
OTHER TEAM MEMBERS				
Title	Signature		Date	

Equal Opportunity Employer / Program • Auxiliary aids and services are available upon request to individuals with disabilities • To request this document in alternative format or for further information about this policy, contact the Division of Developmental Disabilities Customer Service Center at 1-844-770-9500; TTY/TDD Services: 7-1-1 • Disponible en español en línea o en la oficina local