

Child/Adolescent Services TSS Schedule Form

Member Name _____ MAID _____ DOB _____

Evaluator Printed Name _____ Evaluator's Signature _____

Parent Printed Name _____ Parent's Signature _____

Member's Signature (age 14 and older) _____

Parent/Member reviewed: agreed disagreed Date _____

Day/Time	SUN	MON	TUE	WED	THUR	FRI	SAT
	Setting (S,H,C)	Setting (S,H,C)	Setting (S,H,C)	Setting (S,H,C)	Setting (S,H,C)	Setting (S,H,C)	Setting (S,H,C)
7:00 AM							
7:30							
8:00 AM							
8:30							
9:00 AM							
9:30							

Member Name: _____

Day/Time	SUN	MON	TUE	WED	THUR	FRI	SAT
	Setting (S,H,C)	Setting (S,H,C)	Setting (S,H,C)	Setting (S,H,C)	Setting (S,H,C)	Setting (S,H,C)	Setting (S,H,C)
10:00 AM							
10:30							
11:00 AM							
11:30							
12:00 PM							
12:30							
1:00 PM							
1:30							
2:00 PM							

Member Name: _____

Day/Time	SUN	MON	TUE	WED	THUR	FRI	SAT
	Setting (S,H,C)	Setting (S,H,C)	Setting (S,H,C)	Setting (S,H,C)	Setting (S,H,C)	Setting (S,H,C)	Setting (S,H,C)
2:30							
3:00 PM							
3:30							
4:00 PM							
4:30							
5:00 PM							
5:30							
6:00 PM							
6:30							
7:00 PM							

Member Name: _____

Day/Time	SUN	MON	TUE	WED	THUR	FRI	SAT
	Setting (S,H,C)	Setting (S,H,C)	Setting (S,H,C)	Setting (S,H,C)	Setting (S,H,C)	Setting (S,H,C)	Setting (S,H,C)
7:30							
8:00 PM							
8:30							
9:00 PM							
9:30							
Total TSS hrs./day							
						Total TSS hrs./wk.	

Setting: School (S), Home (H) or Community (C)

Time/Activity: Indicate exact times and specific activity that is occurring such as school schedule which requires TSS intervention

TSS Hrs. should be added each day to complete the daily number and also weekly total to match the evaluation recommendation.

TSS Scheduling Worksheet (*Optional page*)

Member Name: _____

Time	Write in day(s) below on the first line and Activity and Behaviors/Symptoms/Focus of Treatment/Goal on the second line (please use to document activity and behaviors/symptoms which are a focus of treatment for TSS intervention during each day and the time period listed on page 1). Note: Days and times for the same activity with the same focus may be documented together.
	Day(s): Activity and behaviors/symptoms/treatment focus/goal:
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