Peer Review Committee (PRC)
Intensive Positive Behavior Support Plan (IPBSP) Checklist

Name: _____ Date: _____

Author: _____ Credentials: _____

Date of Plan: _____ Date of Emergency Implementation: _____

New plan ☐ Review ☐ Date of last PRC review: Behavior Safety Plan is Attached ☐

Required Elements of Intensive Positive Behavior Support Plan (*Full requirements may be found in the Department of Developmental Services Regulations 115 CMR 5.00 https://www.mass.gov/regulations/115-CMR-500-standards-to-promote-dignity-0)*

Does the Plan Being Presented to the PRC Contain These Required Elements?

I. Identifying Information	Yes	No
A. Name	☐	☐
B. Date of Birth	☐	☐
C. Age	☐	☐
D. Day Location	☐	☐
E. Residential Location	☐	☐
F. Clinician's Name, Degree, Licensure, Title	☐	☐
G. Is the author of the plan a PBS qualified clinician? If no, supervising PBS qualified clinician must be present at PRC meeting.	☐	☐
H. Agency name, address, phone number, email	☐	☐

II. Functional Behavior Assessment (FBA): Rationale for Design of the Plan	Yes	No
A. Sources of information for FBA are listed (assessors, indirect/direct tools, date(s) completed)	☐	☐
B. Is the FBA current, and based on available data with conclusions derived from that data?	☐	☐
C. Brief summary of the individual's psychosocial history, strengths, areas of success, life concerns, relevant disabilities, challenging behaviors, medications, medical/physiological/organic issues; etc.	☐	☐
D. Competing Pathways: for each response class, setting events, antecedents, operationally defined challenging behavior(s), maintaining consequences, identified function, desired behavior, functionally equivalent replacement behavior(s) are listed	☐	☐

III. Rationale for Plan	Yes	No
A. Reasoning for need for I-PBSP. Is there a description of the reasons why universal and targeted supports were not sufficient?	☐	☐
B. History of less intrusive interventions given	☐	☐
C. Date of plan, date(s) of revision	☐	☐

IV. Behaviors to Decrease	Yes	No
A. Clear specification of all behaviors the plan seeks to decrease.	☐	☐
B. Operational definitions of all behaviors targeted for decrease.	☐	☐
C. Clear specification of the methods by which targeted behaviors will be measured (frequency, severity, duration, etc.)	☐	☐
D. Baseline and current data for all behaviors.	☐	☐

VI. Replacement Behaviors	Yes	No
A. Clear specification of functionally related alternative behavior(s).	☐	☐
B. Operational definitions of all behaviors targeted for increase.	☐	☐
C. Clear specification of the methods by which targeted behaviors will be measured (frequency, severity, duration, etc.)	☐	☐
D. Baseline and current data for all behaviors.	☐	☐

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VII. Protocol for Acquiring and Maintaining Replacement Behaviors	Yes	No
A. Adequate provision of positive reinforcement.	☐	☐
B. Intervention(s) to increase frequency of replacement behavior(s)	☐	☐

VIII. Interventions	Yes	No
A. Well-defined preventative interventions (such as: environmental modifications, scheduling changes, antecedent modifications, or procedures to attenuate motivating operations effects).	☐	☐
B. Clear identification of all restrictive interventions leading to the need for an I-PBSP.	☐	☐
C. Conditions in which interventions are applied.	☐	☐
D. Duration of intervention per application, if applicable. If time out is included in the plan, it must not exceed 15 minutes.	☐	☐
E. Objective criteria for termination of intervention, if applicable.	☐	☐
F. Interventions are based on the results of the FBA and are evidence-based, least restrictive, and most appropriate.	☐	☐

IX. Monitoring of Plan	Yes	No
A. Provide procedures for monitoring, evaluating and documenting each of the interventions in the plan.	☐	☐
B. Clear statement of how the treating clinician will oversee implementation of plan (i.e., training, frequency of target behaviors, frequency of interventions, safety checks, reinforcement data, and documentation required to comply with the provisions of plan).	☐	☐
C. Criteria that define the need to revise plan and the steps to do so. Are the prevention, teaching, and response strategies sufficient to move an individual to a lower tier of support? Statement of how often clinician will monitor and amend as needed. No more than 60 days?	☐	☐

XI. Risks	Yes	No
A. Identify the risks for physical and/or psychological harm to the individual for each intervention.	☐	☐
B. Is there a risk plan?	☐	☐

XII. Consent and Approval	Yes	No	DATE
A. Informed Consent by INDIVIDUAL and/or LEGALLY AUTHORIZED REPRESENTATIVE	☐	☐	
B. Review and approval by Senior PBS Qualified CLINICIAN.	☐	☐	
C. Review and approval by HUMAN RIGHTS COMMITTEE. Or scheduled date	☐	☐	
C. PHYSICIAN review of plan as indicated, and determination that none of the interventions are medically contraindicated.	☐	☐	
D. Copy of head of program's emergency approval if needed.	☐	☐	

XIII. Decision:

☐	Approved
☐	Approved with the following changes:
☐	Not approved
☐	Further Information requested:

Other Evaluations/Recommendations to Consider:

Date of next review: _____

Participating Peer Review Committee Members:
(If meeting in-person, initial next to name; if meeting virtually, complete roll call)

Peer Review Chairperson and PBS Qualified Clinician	
PBS Qualified Clinician, Licensed Psychologist	PBS Qualified Clinician
PBS Qualified Clinician	