Applied Behavior Analysis for Autism Initial Assessment and Goals and Six Month Reassessment of Goals and Treatment Plan

This form should be completed by the Board Certified Behavior Analyst (BCBA) who will be rendering and/or supervising the services Please complete all parts as clearly and as specifically as possible. Omissions, generalities, and illegibility will result in the form being returned for completion or clarification.

Date of Initial Request:	**Date of Six Month Reassessment:**

Member Name:	Member ID #:	**DOB:**
		Age:

Name of BCBA professional who will perform/supervise service:		
Provider NPI#:	**Is the Provider:** ☐ **Contracted** ☐ **Non-Contracted**	
Tax ID:	**Phone #:**	**Fax #:**
Mailing Address:		
City:	**State:**	**Zip:**
Name of person at provider's office to notify with the Authorization decision (and phone # if different than above)	**ASDs Treating Physician?**	
	How many times have you met with patient?	
	When was most recent contact?	

Clinical Information:
Has a comprehensive diagnostic evaluation been completed (attach copy)? ☐ **Yes** ☐ **No**
If yes, by whom? _____
Date evaluation complete: _____

What is the member's definitive diagnosis: _____

Is the patient receiving Early Intervention Services (if applicable)?	☐ **Yes**	☐ **No**	☐ **Not applicable**
Will the parent/legal guardian be present at all treatment visits?	☐ **Yes**	☐ **No**	☐ **Not applicable**
Has the patient been evaluated by a school?	☐ **Yes**	☐ **No**	**Why?** _____
Is the patient receiving services from a school?	☐ **Yes**	☐ **No**	**Hrs. per day/wk** _____
If child is not attending school, is there a transition goal in place?	☐ **Yes**	☐ **No**	**Describe**_____

Current treatment providers: List all service providers and their roles in the treatment:

Provider Name	Discipline/Specialty	Role	Site of Service

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Member Name:	Member ID#:

CLINICAL INFORMATION CONTINUED:

INITIAL EVAL (DATE):	SIX MONTH RE-EVAL AND UPDATE (DATE):

MEDICATION HISTORY

Has the patient had a medication consultation? ☐ YES ☐ NO If Yes, by whom?	In the past six months has the patient had a medication consultation? ☐ YES ☐ NO If Yes, by whom?

Is the patient receiving medication? ☐ YES ☐ NO ☐ UNKNOWN If yes, please list current meds, with dosage, length of treatment and RESPONSE

PROVIDER ORDERING	MEDICATION	DOSAGE	WHEN STARTED/STOPPED	RESPONSE TO TREATMENT	ON 6 MONTH RE-EVAL. ADDITION/DELETION/CHANGE IN LAST SIX MONTHS

What special services is the patient receiving at school and/or in the community? Includes days/hours of services in school and/or community, if applicable.	On 6 Month Re-Eval. What special services is the patient receiving at school and/or in the community? Includes days/hours of services in school and/or community, if applicable.
NOTE: Services related to autism spectrum disorder provided by school or school personnel are not subject to reimbursement.	**NOTE:** Services related to autism spectrum disorder provided by school or School personnel are not subject to reimbursement.

How long has this patient been receiving ABA services with you or any other provider?

ABA Provider	Start Date	End Date (if applicable)

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Member Name:	Member ID#:

DESCRIBE COMMUNICATION WITH OTHER PROVIDERS INVOLVED IN THE PATIENT'S TREATMENT:

	Contacted?	Discussion	6 Mo. Update Discussion/Date
Occupational Therapist			
Physical Therapist			
Speech Therapist			
Primary Care Physician			
Mental Health Provider			
Other			

Describe parent/caregiver training and participation in treatment sessions:	On 6-Month Re-Eval. Describe parent/caregiver training and participation in treatment sessions:

List Clinical Evaluation Measurement Tool(s) Used in Evaluation, Development of Treatment Plan and Goals:

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Member Name:	Member ID#:

Behaviors targeted for REDUCTION over the previous 6 months:

	Date Target Behavior Identified	Behavior (Example: Bolting from caregiver)	Goal (Ex.: Stay w/caregiver 100% of time when requested)	Current Level of Functioning (Ex.: Bolts 50% of time from care giver when in public)	Target Date for Completion (Ex.: 12/2014)	Status of Goals at Time of 6 Month Re-Evaluation (Ex.: 75% of Goal Achieved, Re-enforce Techniques w/Family, Continue Behavior Modification w/Patient, Target Date 3/31/2015)
1.						
2.						
3.						
4.						
5.						

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Member Name:	Member ID#:

Behaviors targeted for INCREASE over the previous 6 months:

	Date Target Behavior Identified	Behavior (Example: Bolting from caregiver)	Goal (Ex.: Stay w/caregiver 100% of time when requested)	Current Level of Functioning (Ex.: Bolts 50% of time from care giver when in public)	Target Date for Completion (Ex.: 12/2014)	Status of Goals at Time of 6 Month Re-Evaluation (Ex.: 75% of Goal Achieved, Re-enforce Techniques w/Family, Continue Behavior Modification w/Patient, Target Date 3/31/2015)
1.						
2.						
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Member Name:	Member ID#:

Behaviors targeted for REDUCTION in the next 6 months:

	Date Target Behavior Identified	Behavior (Example: Bolting from caregiver)	Goal (Ex.: Stay w/caregiver 100% of time when requested)	Current Level of Functioning (Ex.: Bolts 50% of time from care giver when in public)	Target Date for Completion (Ex.: 12/2014)	Status of Goals at Time of 6 Month Re-Evaluation (Ex.: 75% of Goal Achieved, Re-enforce Techniques w/Family, Continue Behavior Modification w/Patient, Target Date 3/31/2015)
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Behaviors targeted for INCREASE in the next 6 months:

	Date Target Behavior Identified	Behavior (Example: Bolting from caregiver)	Goal (Ex.: Stay w/caregiver 100% of time when requested)	Current Level of Functioning (Ex.: Bolts 50% of time from care giver when in public)	Target Date for Completion (Ex.: 12/2014)	Status of Goals at Time of 6 Month Re-Evaluation (Ex.: 75% of Goal Achieved, Re-enforce Techniques w/Family, Continue Behavior Modification w/Patient, Target Date 3/31/2015)
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REQUEST FOR AUTHORIZATION OF TREATMENT:

I wish to request authorization to see the above noted member _____ Hours a Day, _____ Days a
Week, for _____ Months to work on the goals listed.

**Providers of the services must supply codes.

Code	Description	Frequency	Units

_____ _____

Date **Signature of Treating BCBA Professional**

_____ _____

Date **Physician Signature**

_____

Printed Physician Name

FAX OR EMAIL COMPLETED FORM TO:
PHP at (260) 436-4809 or medmanfax@phpni.com