Applied Behavior Analysis (ABA) Request

for Services Pursuant to Early & Periodic Screening, Diagnostic, and Treatment (EPSDT)

Request type: Initial **Date of Request:** **Is Medicaid Primary?**

Provider Name:	**Provider ID w/ Service Loc:**
BCBA Email Address:	**Clinician Phone Number:**
Name of BCBA:	**Member ID:**
Member Name:	**Member Age and DOB:**
Date of Comprehensive Assessment/ Provider:	**Custodial Agency:**
	Custody Status:

Estimated Duration of ABA Services (planned time from initiation of care to completion, in months)		
Requested Start Date:	**Requested End Date:**	**Hours Requested:**

Do you have a primary insurance provider? If so, please provide a copy of the primary insurer information. Does your primary insurance cover ABA? If so, to what extent (e.g. what is the maximum coverage for ABA services as to total hours, weeks, and/or total amount paid)? Have you been approved for ABA services? If so, for what amount and frequency?

List the guardian's name and relationship to member including their address and phone number. If DHS/OJA involvement, list caseworker contact info including email address.

Is your child currently or have they previously received ABA services? Please list the recommended treatment hours per week. The expectation is for the significant family/caregiver to attend & participate in sessions with the member, as set forth by the treatment provider on the treatment plan.

Has a comprehensive diagnostic evaluation been completed? If yes, please provide a copy with this request. This must be completed prior to start of services.

DSM-5 diagnoses with accompanying specifiers (e.g., 299.00 Autism Spectrum Disorder). The primary diagnosis must be ASD related.	
Diagnoses:	
Primary Diagnosis Code:	**Diagnosis Description:**
Diagnosis Code:	**Diagnosis Description:**

Member's IQ? Please describe how member can benefit from ABA? ABA is not custodial in nature and thus should not be used for Activities of Daily Living (ADLs) only. Is your child on a 504 plan or IEP?

Describe the member's atypical or disruptive behaviors exhibited within the last 30 days that significantly interfere with daily functioning or pose a potentially hazardous risk to the member (e.g. impulsive aggression towards self and others, self injury, intentional property destruction, etc.)

Please document the member's most current disruptive behaviors within the last 14 days, provide specific dates & times. (e.g. what led up to the incidents, what interventions were attempted & were they successful or did they fail, how long did the member's episode of disruptive behaviors last, and did the member sustain injuries to self, others, or property?)

DESCRIBE HOW TREATMENT IS BEING COORDINATED WITH OTHER PROVIDERS INVOLVED IN MEMBER'S CARE

Provider Type (include Provider Name and Phone Number in the boxes)	**Part of member's treatment team?**	**Date Last Contacted**	**Description of Care Coordination**
Primary Care Physician/ Psychiatrist			
Occupational Therapist			

Provider Type (include Provider Name and Phone Number in the boxes)	**Part of member's treatment team?**	**Date Last Contacted**	**Description of Care Coordination**
Physical Therapist			
Speech Therapist			
Behavioral Health Therapist			
School Based Services			
Other Services			

PLEASE NOTE: THIS PAGE WILL BE COMPLETED AFTER THE INITIAL AUTHORIZATION!

BEHAVIORS TARGETED FOR REDUCTIONS

Date Behavior was Identified	Behavior (e.g., bolting from caregiver, aggression, etc) Please be specific.	Please describe where services were provided within this 30 day period? (i.e. home, office, etc.)	Target Date for Completion