INITIAL AUTHORIZATION FOR ABA/BEHAVIORAL SERVICES

Member Name: _____

Member ID#: _____ Date of Birth: _____

Requesting Provider: _____

Phone Number: _____ NPI #: _____

Provider Address: _____

Date of Initial Evaluation:			
Services Requested:			
CPT		Hours Per Week:	
CPT		Hours Per Week:	
CPT		Hours Per Week:	
CPT		Hours Per Week:	
CPT		Hours Per Week:	

DIAGNOSIS AND CARE COORDINATION:		
Member diagnosed with ASD	☐ Yes	☐ No
Age of member when diagnosis confirmed		
Diagnosis supported by*: Structured parent/caregiver interview	☐ Yes	☐ No
Direct behavioral observation	☐ Yes	☐ No
*Provider may submit all evidence based screening and scaling results used in determining the diagnosis with this form.		
Communication and social interaction deficits exhibited in at least 2 different settings	☐ Yes	☐ No
Repetitive/Restrictive behaviors evident	☐ Yes	☐ No
Suspicion of severe/profound intellectual disability	☐ Yes	☐ No
Estimated IQ greater than 35	☐ Yes	☐ No
Blind and/or deaf	☐ Yes	☐ No

SCHOOL/PRESCHOOL / EARLY INTERVENTION SERVICES PROVIDED:	
School/preschool/early intervention services provided	☐ Yes ☐ No
Types of services/Number of hours of each service provided	
1	
2	
3	
4	
5	
Behaviors Targeted:	
1	
2	
3	
4	
5	

COORDINATION WITH OTHER THERAPY PROVIDERS:	
BCBA Coordinating treatment with all other allied health services & has obtained specific info	
1) Types of therapy provided and hours per week	
a)	
b)	
c)	
d)	
e)	
2) Behaviors/Deficits targeted	
a)	
b)	
c)	
d)	
e)	
3) Coordination not achieved with at least 1 other provider despite at least 3 attempts	☐ Yes ☐ No
4) Other therapy services provided to patient	☐ Yes ☐ No
5) Up to 12 hours per year of consultation with other providers/agencies/school personnel	☐ Yes ☐ No

TREATMENT PLAN	
Focused on specific behavioral targets	
A) Communication/Language	☐ Yes ☐ No
B) Social/Family Interactions	☐ Yes ☐ No
C) Repetitive/Restrictive Behaviors	
1) Behaviors interfere with functioning/relationships	☐ Yes ☐ No
2) Potential to harm self/others	☐ Yes ☐ No
3) ADLs/IADLS	☐ Yes ☐ No
4) Disruptive/Aggressive/Self-Injurious behaviors	☐ Yes ☐ No
5) Behavioral targets defined by objective measurements	☐ Yes ☐ No
6) Procedure in place for data collection & analysis- Describe:	
7) Strategies planned to promote generalization- Describe:	
8) Parent/Caregiver Training Scheduled	☐ Yes ☐ No
9) Use of mechanical restraint not expected	☐ Yes ☐ No

PROVIDER QUALIFICATIONS	
Case Supervised by state licensed/BCBA/BCBA-D	☐ Yes ☐ No
A) Supervisor experienced in ASD	☐ Yes ☐ No
Planned Supervision of case	
1) Greater than 4 supervision session/month	☐ Yes ☐ No
2) Greater than 1 hour of supervision per 15 hours of direct treatment	☐ Yes ☐ No
Direct/Video-based supervision planned	
1) Greater than 1 time in two weeks	☐ Yes ☐ No
2) Greater than 1 hour per 30 hours of direct treatment	☐ Yes ☐ No
Direct treatment providers:	
B) All direct treatment providers are credentialed for independent practice of ABA	☐ Yes ☐ No
1) BCBA/BCBA-D	☐ Yes ☐ No
2) Licensed behavior analyst by state statute	☐ Yes ☐ No

TREATMENT PLAN:	
*Plan must be child-centered, strength-based, family focused, community-based, multisystem, and culturally-competent. Parental training must be involved so they can provide additional hours of intervention.	
Goal 1:	
	Objective:
	As Evidenced By:
	Objective:
	As Evidenced By:
	Objective:
	As Evidenced By:
Goal 2:	
	Objective:
	As Evidenced By:
	Objective:
	As Evidenced By:
	Objective:
	As Evidenced By:
Goal 3:	
	Objective:
	As Evidenced By:
	Objective:
	As Evidenced By:
	Objective:
	As Evidenced By:

The HealthPlan

RISK ASSESSMENT*:
Past Attempts to Harm Self or Others: ☐ None ☐ Self ☐ Others
Comments:
Current Risk of Harm to Self: ☐ None ☐ Low ☐ Moderate ☐ High
Comments:
Current Risk of Harm to Others: ☐ None ☐ Low ☐ Moderate ☐ High
Comments:
Functional Impairment (only indicate the impairments that are present) Social Interaction * If potentially harmful behaviors exist, please submit full risk assessment and crisis plan.

TARGETED INTERVENTIONS AIMED AT SPECIFIC BEHAVIORS:	
Intervention 1:	a.) description of intervention:
	b.) risk analysis:
Intervention 2:	a.) description of intervention:
	b.) risk analysis:
Intervention 3:	a.) description of intervention:
	b.) risk analysis:
Intervention 4:	a.) description of intervention:
	b.) risk analysis:

ADDITIONAL INTERVENTIONS:

IF APPLICABLE, WAS THE PLAN SUBMITTED AND APPROVED BY THE HUMAN RIGHTS COMMITTEE?
☐ Yes ☐ No

Signature:

Date:

REVIEWED 08/23/2018