Instructions for Ongoing Treatment Authorization

Applied Behavioral Analysis

This form is to request ongoing ABA treatment. Please attach this form to the Connect submission when you request authorization.
The CareOregon Behavioral Health Utilization Management department is available by phone at 503-416-3404.

Additional items needed for authorization:

- Completed ABA assessment
- Clear treatment goals
- Clear frequency
- Clear duration
- Anticipated prognosis with behavioral interventions
- Professional and family/schools involved with implementation of goals

Authorization determinations will be made within 14 days of receipt of request.

Service Support Assessment for Applied Behavioral Analysis Services

Assessing agency name:		**Assessment date:**
Client's name:	**Client's Oregon Medicaid ID:**	**Age:**

Clinical Information		
Diagnosis:	**Date of Diagnosis:**	**Provisional Diagnosis:** Yes ☐ No ☐
Diagnosing Clinician:	**Clinician's phone:**	
	Clinician's e-mail:	
Client's Primary Supporter(s):	**Relationship:**	
Phone (home/cell):	**Phone (work):**	
Client's Name:	**Primary Language:** English ☐ Spanish ☐ Other ☐ _____	
Client's DOB:	**Gender:** Male ☐ Female ☐	
Client's Address: _____ Street Apt # City State ZIP Code		

History of previous treatments *(mark all that apply)*:

- ☐ Currently receiving services
- ☐ May require additional and/or more intensive services
- ☐ Services previously attempted and/or family did not participate
- ☐ Services attempted but goals and objectives not met.

Home placement status change due to symptoms *(mark all that apply)*:

- ☐ Currently in the home with no previous history of out of home placement
- ☐ Currently at risk of out of home placement
- ☐ Currently placed outside of primary caregiver's home
- ☐ **Urgent request, danger of injury to self/others/property and/or threat to current placement**

School placement status *(mark all that apply)*:

- ☐ If school age, currently receiving services
- ☐ If school age, receiving services with risk of out of school placement
- ☐ Not attending school
- ☐ Attending Day Program, if so, which program: _____
- ☐ Attending school and/or state preschool program
- ☐ Current Individualized Education Program (IEP)

School District of Attendance: _____ School Name: _____

Date of Annual IEP:_____ IEP Attached: **Yes** ☐ **No** ☐

Current access to other services/supports *(mark all that apply)*:

- ☐ Oregon Developmental Disabilities Services (ODDS) supports

Service Coordinator's name, if known: _____

- ☐ Other medical/psychological services being provided (i.e., speech therapy, occupational therapy, etc.)

I understand that caregiver participation is an essential component of _____'s program. I and/or an approved substitute will attend all treatment sessions and will actively participate and assist in providing treatment including but not limited to collecting data, attending staff meetings, and attending training sessions. Failure to participate can lead to the discontinuation of services for _____.

Caregiver Signature: _____ Date: _____

Service Support Assessment		***(Circle Appropriate Response)***	
Domain 1: Communication		**Yes (Y)**	**No (N)**
1	Non-Verbal	Y	N
2	Verbal	Y	N
3	Verbally able to initiate a request to caregiver	Y	N
4	Verbally able to initiate a request to familiar people	Y	N
5	Understands and/or responds appropriately to other's requests	Y	N
6	Can verbally identify number objects	Y	N
7	Can initiate and maintain conversation	Y	N
8	Can follow a simple age appropriate instruction	Y	N

Service Support Assessment		***(Circle Appropriate Response)***	
Domain 2: Social		**Yes (Y)**	**No (N)**
1	Tolerates physical contact and/or close proximity with others	Y	N
2	Shows interest in peers and/or familiar people	Y	N
3	Parallel plays with peers	Y	N
4	Demonstrates imitative play and/or play activities	Y	N
5	Interactively plays with same age peers	Y	N
6	Initiates play interaction with different individuals	Y	N
7	Demonstrates ability to empathize and/or relate to others	Y	N

Domain 3: Behaviors of Concern *(check category and all behaviors that apply)*			**Behaviors have occurred in locations** *(mark all that apply)*	**Approximate Rates of Behavior**
☐ Physical Aggression	☐ Hitting ☐ Kicking ☐ Spitting ☐ Grabbing/Pinching	☐ Biting ☐ Throwing Objects ☐ Other: _____ ☐ Other: _____	☐ Home ☐ Community ☐ School	☐ 1-3 times per week ☐ 4-6 times per week ☐ 7-10 times per week ☐ greater than 10 times per week
☐ Self-injury	☐ Head Banging ☐ Hits self ☐ Bites self	☐ Other: _____ ☐ Other: _____	☐ Home ☐ Community ☐ School	☐ 1-3 times per week ☐ 4-6 times per week ☐ 7-10 times per week ☐ greater than 10 times per week
☐ Property Destruction	☐ Breaks Objects ☐ Other: _____	☐ Other: _____ ☐ Other: _____	☐ Home ☐ Community ☐ School	☐ 1-3 times per week ☐ 4-6 times per week ☐ 7-10 times per week ☐ greater than 10 times per week
☐ Behavior Tantrums	☐ Screaming/Yelling ☐ Crying	☐ Vocalized Aggression ☐ Other: _____	☐ Home ☐ Community ☐ School	☐ 1-3 times per week ☐ 4-6 times per week ☐ 7-10 times per week ☐ greater than 10 times per week
☐ Stereotypic/Self-Stimulatory Behavior	☐ Pacing ☐ Rocking	☐ Hand Flapping ☐ Other: _____	☐ Home ☐ Community ☐ School	☐ 1-3 times per week ☐ 4-6 times per week ☐ 7-10 times per week ☐ greater than 10 times per week
☐ Community Safety/Awareness	☐ Elopement ☐ Inappropriate Social exchanges	☐ Impulsivity ☐ Other: _____	☐ Home ☐ Community ☐ School	☐ 1-3 times per week ☐ 4-6 times per week ☐ 7-10 times per week ☐ greater than 10 times per week
☐ Self-care	☐ Toileting ☐ Hygiene ☐ Feeding	☐ Dressing ☐ Other: _____	☐ Home ☐ Community ☐ School	☐ 1-3 times per week ☐ 4-6 times per week ☐ 7-10 times per week ☐ greater than 10 times per week
☐ Inappropriate Sexual Behavior	☐ Inappropriate Touching of Self and/or others	☐ Public Masturbation ☐ Other: _____	☐ Home ☐ Community ☐ School	☐ 1-3 times per week ☐ 4-6 times per week ☐ 7-10 times per week ☐ greater than 10 times per week

Signatures

_____	_____	_____
Assessor signature	Assessor name and title	Date
_____	_____	_____
Parent/guardian signature	Parent/guardian name	Date
_____	_____	_____
Provider representative signature	Representative name and title	Date