Minuteman Health

APPLIED BEHAVIOR ANALYSIS (ABA) FOR AUTISM SPECTRUM DISORDER (ASD)

BEHAVIORAL HEALTH DEPARTMENT
PHONE: (413) 787-4000, EXT. 5028 FAX: (413) 233-2800

Fax completed form to the Minuteman Health, Inc. (MHI) Behavioral Health Department and attach the ABA Diagnostic and Functional Assessment Report completed by Board Certified Behavior Analyst within the last 60 days

1. Member's Name: _____ DOB: _____ MHI Member ID#:_____
2. Member's Parent[s] or Legal Guardian[s]:
   Name: _____ Relationship: _____ Phone:_____
   Name: _____ Relationship: _____ Phone: _____
3. ABA Provider: _____ Degree/License: _____ MHI Provider ID #:_____
4. Street Address:_____ City/State:_____
5. Telephone #: _____ Fax #: _____
6. Business Office Contact: _____ Telephone #:_____
7. Requested Start Date: _____ Anticipated Discharge Date:_____
8. Name of Referral Source:_____

IF PROVIDER IS A FACILITY OR GROUP, OR SUPERVISING ANOTHER PRACTITIONER, LIST THE OTHER TEAM MEMBER[S]

1. Name:_____ Degree/License: _____ Other Certification:_____
   Name:_____ Degree/License: _____ Other Certification:_____
   Name:_____ Degree/License: _____ Other Certification:_____
   Name:_____ Degree/License: _____ Other Certification:_____

OTHER PROVIDERS AND SERVICES

1. School: _____ SPED Contact: _____ Phone:_____
2. Psychotherapist:_____ Specialty / Certification: _____ Phone:_____
3 Psychiatrist: _____ Specialty / Certification: _____ Phone:_____
4. Physical Therapist: _____ Specialty / Certification: _____ Phone:_____
5. Occupational Therapist:_____ Specialty / Certification: _____ Phone:_____
6. Speech Therapist:_____ Specialty / Certification: _____ Phone:_____
7. Early Intervention Provider:_____

HCPC Code	Services Requested	Hours per Month
H0031	Code for treatment and planning; 1 hour	hours/month
H0032	Code for supervision; 1 hour	hours/month
H2012	Direct Service, 1 hour increment, BCBA	hours/month
H2019	Direct Service; 15 minute increment, paraprofessional	units/week

Supervision Modalities: ☐ Individual ☐ Group ☐ Direct

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Member Name: _____**Date of Birth**_____ **MHI Member ID#**_____

1. Summary of Functional Capacities and Areas of Impairment (Indicate which Assessment tools were used):

_____

_____

_____

_____

2. Biopsychosocial Summary including household members, relevant environmental factors and medical issues, current educational situation and services: _____

_____

_____

_____

_____

DIAGNOSES

Axis I Primary _____ Secondary _____

Axis II Primary_____ Secondary _____

Axis III _____

Axis IV _____

Axis V _____

TREATMENT PLAN (ATTACH BASELINE LEVEL DATA FOR EACH AREA OF CONCERN)

AREA OF CONCERN #1:

1. Behavior/Deficit to Decrease:_____
2. Behavior/Skill to Increase: _____
3. Method[s]:_____

_____

4. Parent/Guardian Skill[s]/Goals:_____

_____

5. Objective Criteria for Attainment of Goal: _____

_____

_____

6. Target Date for Introduction of Goal:_____ Date for Attainment of Goal: _____

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Member Name: _____ **Date of Birth**_____ **MHI Member ID#**_____

AREA OF CONCERN #2:

1. Behavior/Deficit to Decrease: _____
2. Behavior/Skill to Increase: _____
3. Method[s]:_____

   _____
4. Parent/Guardian Skill[s]/Goals:_____

   _____
5. Objective Criteria for Attainment of Goal: _____

   _____

   _____
6. Target Date for Attainment of Goal: _____ Date for Attainment of Goal_____

AREA OF CONCERN #3:

1. Behavior/Deficit to Decrease: _____
2. Behavior/Skill to Increase: _____
3. Method[s]:_____

   _____
4. Parent/Guardian Skill[s]/Goals:_____

   _____
5. Objective Criteria for Attainment of Goal: _____

   _____

   _____
6. Target Date for Attainment of Goal: _____ Date for Attainment of Goal: _____

Attach additional pages if necessary to identify other areas of concern

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Member Name: _____ **Date of Birth:**_____ **MHI Member ID #:**_____

TRANSITION PLAN:

Is child:

- ☐ Beginning treatment
- ☐ Transitioning from a home-based intensive ABA-based program to a lesser level of care
- ☐ Transitioning from a most to least restrictive setting
- ☐ Transitioning from a home-based ABA intervention program to a school-based program

1. Projected Transition Plan/Goals:_____
   _____
   _____
   _____
2. If clinically necessary, what is the prevention plan and/or resolution of crises, e.g. behavior, antecendents, consequences, prevention, baseline, de-escalation procedures_____
   _____
   _____
   _____
3. How will child transition into adulthood?_____
   _____
4. Projected Criteria for Discharge:_____
   _____
   _____
5. Expected Discharge Date: _____ Next Level of Care: _____

CONTACT INFORMATION WHO CAN ASSIST MEMBER IN RESOLVING CRISES

Contact Names _____ Phone # _____ Relation_____
Contact Names _____ Phone # _____ Relation_____
Contact Names _____ Phone # _____ Relation_____
Contact Names _____ Phone # _____ Relation_____

_____ _____

Provider's Signature Degree/License Date