Ongoing Treatment Authorization Request Applied Behavioral Analysis (ABA)

This form is to request ongoing ABA treatment. *Please submit this completed request by fax to 503-416-3713 or toll-free 888-272-9315.*

The CareOregon 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 10 business 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 fax number: _____

Client's primary supporter(s): _____

Phone (home/cell): _____ Phone (work): _____

Client's name: _____ Client's DOB: _____

Primary language: ☐ English ☐ Spanish ☐ Other _____ Gender: ○ Male ○ Female

Client's address: _____

Street / Apt # City State

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 — 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 others' requests				○ Y	○ N
6. Can verbally identify number objects				○ Y	○ N
7. Can initiate and maintain conversation	○ 0-20	○ 21-40	○ 41-60		○ N
8. Can follow a simple age appropriate instruction				○ Y	○ N

Service Support Assessment — 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 ☐ Biting ☐ Grabbing/pinching ☐ Throwing objects ☐ Other: _____ ☐ Other: _____	☐ Home ☐ Community ☐ School	○ 1-3 times per week ○ 4-6 times per week ○ 7-10 times per week ○ **More** 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 ○ **More** 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 ○ **More** than 10 times per week
Behavior tantrums ☐ Screaming/yelling ☐ Vocalized aggression ☐ Crying ☐ Other: _____	☐ Home ☐ Community ☐ School	○ 1-3 times per week ○ 4-6 times per week ○ 7-10 times per week ○ **More** than 10 times per week
Stereotypic/self-stimulatory behavior ☐ Pacing ☐ Hand flapping ☐ Rocking ☐ Other: _____	☐ Home ☐ Community ☐ School	○ 1-3 times per week ○ 4-6 times per week ○ 7-10 times per week ○ **More** 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 ○ **More** 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 ○ **More** 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 ○ **More** than 10 times per week

Signatures

Assessor signature _____

Assessor name and title _____ Date _____

Parent/guardian signature _____

Parent/guardian name _____ Date _____

Provider representative signature _____

Provider representative name and title _____ Date _____