One Monarch Place – Suite 1500
Springfield, MA 01144-1500
HNE.COM

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 HNE Behavioral Health Department
Attach the ABA Diagnostic and Functional Assessment Report completed by Board Certified Behavior Analyst within the last 60 days

Member's Name ___________________________________ DOB ____________ HNE Member ID #_____________________

Member's Parent[s] or Legal Guardian[s]

Name _____________________________ Relationship ______________________ Phone ______________________

Name _____________________________ Relationship ______________________ Phone ______________________

ABA Provider _________________________ Degree/License __________________ HNE Provider ID # __ __ __ __ __

Address ____City/State_______________________________________

Telephone # ____________________ Fax # ___________________

Business Office Contact ____ Telephone #_____________________________

Requested Start Date ____________________ Anticipated Discharge Date____

Name of Referral Source _________________________

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

Name _________________________________ Degree/License _______________ Other Certification __________________

Name _________________________________ Degree/License _______________ Other Certification ___________________

Name _________________________________ Degree/License _______________ Other Certification ___________________

Name _________________________________ Degree/License _______________ Other Certification ___________________

OTHER PROVIDERS AND SERVICES

School __________________________________ SPED Contact ________________________ Phone_______________

Psychotherapist ___________________________ Specialty / Certification ________________ Phone ________________

Psychiatrist _______________________________ Specialty / Certification ________________ Phone ________________

Physical Therapist _________________________ Specialty / Certification ________________ Phone ________________

Occupational Therapist _____________________ Specialty / Certification ________________ Phone ________________

Speech Therapist __________________________ Specialty / Certification ________________ Phone ________________

Early Intervention Provider____ Phone ________________

HCPC Code	Services Requested	Limited Hours
H0031	Code for treatment and planning; 1 hour	4 hours/month
H0032	Code for supervision; 1 hour	4 hours/month
H2012	Direct Service, 1 hour increment, BCBA	4 hours/month
H2019	Direct Service, 15 minute increment, paraprofessional	160 units/week

Supervision Modalities: ☐ Individual ☐ Group ☐ Direct

(CONTINUES ON NEXT PAGE)

Member Name: ____________________________ Date of Birth: _____________ HNE Member ID#: ____________________

Summary of Functional Capacities and Areas of Impairment (Indicate which assessment tools were used):

____

____

____

____

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)

<u>AREA OF CONCERN #1</u>

Behavior/Deficit to Decrease____

Behavior/Skill to Increase ____

Method[s] ____

____

Parent/Guardian Skill[s]/Goals ____

____

Objective Criteria for Attainment of Goal ____

____

____

Target Date for Introduction of Goal _________________ Date for Attainment of Goal _________________

(CONTINUES ON NEXT PAGE)

Member Name: _____________________________ Date of Birth: _____________ HNE Member ID#: ____________________

AREA OF CONCERN #2

Behavior/Deficit to Decrease ____

Behavior/Skill to Increase ____

Method[s] ____

____

Parent/Guardian Skill[s]/Goals ____

____

Objective Criteria for Attainment of Goal ____

____

____

Target Date for Introduction of Goal __________________ Date for Attainment of Goal __________________

AREA OF CONCERN #3

Behavior/Deficit to Decrease ____

Behavior/Skill to Increase____

Method[s] ____

____

Parent/Guardian Skill[s]/Goals ____

____

Objective Criteria for Attainment of Goal ____

____

____

Target Date for Introduction of Goal __________________ Date for Attainment of Goal __________________

Attach additional pages if necessary to identify other areas of concern

(CONTINUES ON NEXT PAGE)

Member Name: _____________________________ **Date of Birth:** _____________ **HNE 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 environment placement
- ☐ Transitioning from a home-based ABA intervention program to a school-based program

Projected Transition Plan/Goals____

____

____

____

____

If clinically necessary, what is the prevention plan and/or resolution of crises, e.g. behavior, antecedents, consequences, prevention, baseline, de-escalation procedures ____

____

____

____

____

How will child transition into adulthood ____

____

Projected Criteria for Discharge ____

____

____

Expected Discharge Date _________________________ Next Level of Care _______________________________________

Linkage with other services ____

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 ___________________