**TREATMENT PLAN**
**FOR THE TREATMENT OF AUTISM SPECTRUM DISORDERS**

***Information provided will be protected in accordance with HIPAA requirements and other applicable confidentiality regulations.***

## Parent/Legal Guardian and Patient Information:

Subscriber's Last Name/First Name: _____

Subscriber #:_____Subscriber Phone #:_____

Patient's Last Name/First Name: _____

Patient's DOB: _____

## Provider Information:

_____

Name of Facility/Group/Individual Provider Federal Tax ID#:

_____

Name of Executive Director Telephone # Email Address

_____

Street Address City State Zip

_____

Name of Practitioner Supervising Treatment Licensure/Certification State

_____

BCBA or Licensed Supervisor Phone Number

For any other individuals providing services, please provide information below:

| Other Provider's Name | Degree | Credentials/License | Other/Training | Background Check Yes/No |
|---|---|---|---|---|
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## Assessment, Treatment Information and Recommendations:

Supervision Protocol (frequency, duration and team members involved):

_____

_____

_____

Psychosocial Information (including family composition, recent family changes; medications; medical conditions; other psychological conditions; other treatments the client is receiving; school functioning and supports):

_____

_____

_____

_____

Current Problem Areas (how the relate to ASD diagnosis):

_____

_____

_____

_____

_____

Assessment of Current Functioning (observed via FBA, ABLLS, or VB-MAPP, etc):

_____

_____

_____

_____

Clinical Interpretation/Response to Treatment (including a description of why ABA services are needed, explain progress to treatment):

_____

_____

_____

_____

_____

Behavior Intervention Plan (if needed):

_____

_____

_____

_____

Crisis Management (medical/weather crisis AND behavioral crisis):

_____

_____

_____

_____

Transition Plans (how services will be faded, transitions to school or adulthood.):

_____

_____

_____

_____

Coordination of Care (i.e. speech therapy, occupational therapy, physical therapy, outpatient therapy, medication management, interventions in the school)

_____

_____

_____

_____

Parent Involvement (current level of involvement, how involved, parent goals/training):

_____

_____

_____

_____

Discharge Criteria (see treatment plan guidelines):

_____

_____

_____

_____

**Behaviors Targeted for Reduction. For *Current Level*, indicate percentage or average. In addition, should provide baseline data and progress data. Use additional sheets and/or attach graphs as needed.**

| Behavior | Objective | Baseline Data | Current Level | Mastery Criteria | Target Date |
|---|---|---|---|---|---|
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**Behaviors Targeted for Increase for *Current Level*, indicate percentage or average. In addition, should provide baseline data and progress data. Use additional sheets and/or attach graphs as needed.**

| Behavior | Objective | Baseline Data | Current Level | Mastery Criteria | Target Date |
|---|---|---|---|---|---|
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**ABA Service Request**

| HCPC Code | Service | Hours Per Month | Rate Per Hour |
|---|---|---|---|
| H0031 (1 hour) | Assessment & Treatment Planning by BCBA or licensed ABA provider | | |
| H0032 (1 hour) | Supervision of paraprofessional by BCBA or licensed ABA provider | | |
| H2012 (1 hour) | Direct service provided by BCBA or licensed ABA provider (i.e. this can include parent training) | | |
| H2019 (15 min.) | Paraprofessional providing direct services | | |
| H2014 (15 min.) | Social Skills Group | | |

_____ _____

Provider (BCBA or Licensed Mental Health Provider) Date

_____ _____

Parent Signature Date

***Please return the completed form to the attention of the Care Advocate at the address or fax shown on the letter that came with this form, and enclose additional pages as needed.***