Applied Behavior Analysis Service Request

PATIENT: Name: _____
ID: _____ DOB: _____
Address: _____
City: _____ State: _____ Zip: _____

PROVIDER: _____ ID: _____
Provider and Credential
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

COORDINATION OF CARE:

	Yes	No
Parent/Caregiver is willing to participate in treatment:	☐	☐
I have communicated with patient's PCP or specialist:	☐	☐
I have communicated with patient's psychiatrist or therapist:	☐	☐
Child has an IEP in place:	☐	☐

DSM or ICD10 DIAGNOSIS (List Primary & Co-Occurring) code + description:

_____
_____
_____

MEDICATIONS (attach if additional)
Prescribed by ☐ PCP ☐ Psychiatrist ☐ APRN

1. _____
2. _____
3. _____
4. _____

If affective or psychotic disorder is present and no medications are prescribed, please explain:
_____

RISK ASSESSMENT
☐ Suicidal ☐ Ideation ☐ Planned ☐ Imminent Intent ☐ History of self-harming behavior
☐ Homicidal ☐ Ideation ☐ Planned ☐ Imminent Intent ☐ History of behavior harming others

SYMPTOMS — if present, check degree or indicate N/A

	Mild	Mod.	Sev.	NA		Mild	Mod.	Sev.	N/A
Anxiety	☐	☐	☐	☐	Inattention	☐	☐	☐	☐
Depression	☐	☐	☐	☐	Obsessions	☐	☐	☐	☐
Hyperactivity	☐	☐	☐	☐	Sleep Disturbance	☐	☐	☐	☐

BEHAVIORS TARGETED FOR REEDUCTION — if present, check degree or indicate N/A

	Mild	Mod.	Sev.	N/A		Mild	Mod.	Sev.	N/A
Self-injury	☐	☐	☐	☐	Phys. Aggression	☐	☐	☐	☐
Prop. Destruct.	☐	☐	☐	☐	Verbal Aggression	☐	☐	☐	☐
Threat Making	☐	☐	☐	☐	Non-Compliance	☐	☐	☐	☐
Tantrums	☐	☐	☐	☐	Stereotypy	☐	☐	☐	☐
Elopement	☐	☐	☐	☐	Toileting Issues	☐	☐	☐	☐
Inapp. Touch	☐	☐	☐	☐	Other:_____	☐	☐	☐	☐

FUNCTIONAL IMPAIRMENT – if present, check degree or indicate N/A

	Mild	Mod.	Sev.	N/A		Mild	Mod.	Sev.	N/A
ADLSs	☐	☐	☐	☐	Physical Health	☐	☐	☐	☐
Family/Relationships	☐	☐	☐	☐	Work/School	☐	☐	☐	☐
Social Skills	☐	☐	☐	☐	Substance Abuse	☐	☐	☐	☐
Functional Communication	☐	☐	☐	☐	Other:_____	☐	☐	☐	☐

TREATMENT PLAN
☐ Parent/Caregiver training will be provided
☐ Treatment providers are BCBAs, BCaBAs, and/or Registered Behavior Technicians under BCBA
☐ For initial request for ABA services, must attach outcome of Functional Behavioral Assessment
☐ For ongoing ABA services, must attach ADOS or evidence-based tool for ongoing services
#hours/week provided to date: _____
Level of improvement to date: ☐Minor ☐Mod ☐Major ☐None ☐ Chronic cond maintenance

Please indicate code type for billing and list all units/hours requested per month

☐ HCPCS Code	☐ CPT Code	Service Type	Visits per Month	Hours/Units per Month
H0031 (per hour)	☐ 0359T ☐ 0360T/0361T	Treatment planning and assessment		
H0032 (per hour)	0368T/0369T	Supervision by BCBA		
H2012 (per hour)	☐ 0370T ☐ 0371T	Parent training by BCBA		
H2012 (per hour)	0364T/0365T	Direct ABA services by BCBA		
H2019 (15min unit)	☐ 0370T (untimed) ☐ 0371T (untimed)	Parent training by paraprofessional		
H2019 (15min unit)	0364T/0365T	Direct ABA services by paraprofessional		
H2014 (15min unit)	0366T/0367T	Group skills training		
Other:	Other:	Other:		

This request for services is for: ☐ **Initial ABA Request** ☐ **Continued ABA Services**

Initial start date of this ABA episode of care: _____

Start date of ongoing services (*within 14 days of request): _____

Anticipated duration of ABA services remaining to meet treatment goals:
☐ Less than 1 month ☐ 1 to 3 months ☐ 4 to 6 months ☐ more than 6 months

_____ _____
Provider Signature Date

My signature confirms that I am providing the requested services and have completed this form accurately.