# Behavioral Health Treatment
# Reporting Template

(*Report Type: Functional Behavioral Assessment, Progress, Closing Report*)

| IDENTIFYING INFORMATION | |
|---|---|
| **Member Information** | |
| **Member's Name:** | |
| **Member's Medical ID:** | |
| **Date of Birth:** | |
| **Member's Age:** | |
| **Primary Diagnosis:** | |
| **Health Plan Name:** | |
| **Caregiver's Name:** | |
| **Caregiver's Phone Number:** | |
| **Preferred Language:** | |
| **Home Address:** | |
| **PCP's Name:** | |
| **PCP's Phone Number:** | |

| **Provider Information** | |
|---|---|
| **Agency Name:** | |
| **Agency Address:** | |
| **QAS Provider:** *Name and Credential* | |
| **Mid-Level Supervisor:** *Name and Credential* | |
| **Provider Phone:** | |
| **Provider Email:** | |
| **Location(s) of Services:** | |

| **Report Information** | |
|---|---|
| **Date of Current Report:** | |
| **Type of Current Report:** *(e.g., FBA, PR #, Closing)* | |
| **Authorization Period:** | |
| Percent of session cancelations by provider: | |
| Percent of session cancelations by caregiver: | |
| **Date of first available appointment offered to family:** (*FBA and PR 1)* | |
| **10-Day timeline met:** *(FBA and PR 1)* | ☐Yes ☐No |

| | |
|---|---|
| **If 10-Day timeline not met, provide rationale:** *(FBA and PR 1)* | |

| REFERRAL INFORMATION | |
|---|---|
| **Source of Referral** | **Reason for Referral** |
| ☐ L.A. Care Health Plan<br>☐ Legal Guardian<br>☐ Other: | |

| BACKGROUND INFORMATION | |
|---|---|
| **Physical and Mental Health History** | |
| **Allergies:** | |
| **Gender specific conditions that may impact treatment:** | |
| **History of hospitalizations and recent injures:** | |
| **Medications:** | |
| **Vision and hearing issues:** | |
| **Sleeping difficulties:** | |
| **Food selectivity/refusal:** | |
| **Swallowing food or liquids issues:** | |

| **Family Structure** | |
|---|---|
| **Primary caregiver:** | |
| **Home language:** | |
| **Number of people living in the household:** | |
| **Space(s) to hold the sessions:** | |
| **Level of environmental enrichment:** | |
| **Recent changes in the household:** | |
| **Department of Child and Family Services (DCFS) involvement (if applicable):** | |
| **Placement in foster/group home (if applicable):** | |

| **Availability for ABA Services** | | | |
|---|---|---|---|
| ***Member's Availability*** | | ***Caregiver's Availability for Parent Education*** | |
| Monday: | *(include time frame)* | Monday: | *(include time frame)* |
| Tuesday: | | Tuesday: | |
| Wednesday: | | Wednesday: | |
| Thursday: | | Thursday: | |
| Friday: | | Friday: | |
| Saturday: | | Saturday: | |
| Sunday: | | Sunday: | |

| Current or Prior Home or Outpatient Services | | | |
|---|---|---|---|
| **Service type** | **Number of treatment hours per week** | **Dates of services** | **Provider** |
| | | | |
| | | | |
| | | | |

| School History and Current School Based Services | |
|---|---|
| **School Name:** | |
| **School start and end times:** | |
| **Grade:** | |
| **School District:** | |
| **Special Education Eligibility:** | |
| **Date of initial IEP** (if applicable): | |
| **Date of the most recent IEP:** | |
| **Did the BCBA attend the IEP in the last reporting period?** | |
| **Did the BCBA coordinate care with the school, in the last reporting period?** If so, explain: | |
| **Are the services identified in the IEP being provided?** Identify any barriers, if any: | |
| **Plans to address any IEP barriers** (if applicable)**:** | |
| **Name and contact information of the service provider(s) (funded by IEP) in the school setting** (if applicable)**:** | |

| Current Placement |
|---|
| ☐ Fully included in a general education classroom |
| ☐ General education class with Resource Specialist Support |
| ☐ Special Day Program Class with inclusion in general education classes |
| ☐ Special Day Program Class with inclusion only during school wide activities |
| ☐ Special Education Center |
| ☐ Non-Public School Placement (e.g., Help Group) |

| Special Education Related Services Provided at School | | | |
|---|---|---|---|
| Services: | Minutes/Week | Services: | Minutes/Week |
| ☐ Language and Speech (LAS) | | ☐ Recreational Therapy (RT) | |
| ☐ Occupational Therapy (OT) | | ☐ Mental Health Counseling | |
| ☐ Adaptive Physical Education (APE) | | ☐ Assistive Technology (AT) | |
| ☐ Physical Therapy (PT) | | ☐ Audiology (AUD) | |
| ☐ Behavior Intervention Consultation (BIC) | | ☐ Orientation and Mobility (O and M) | |
| ☐ Behavior Intervention Development (BID) | | ☐ Orthopedic Impairment Itinerant (OI) | |
| ☐ Behavior Intervention Implementation (BII) | | ☐ DIS Counseling (provided by the school psychologist) | |
| ☐ Deaf and Hard of Hearing (DHH) | | ☐ Visual Impairment Itinerant (VI) | |

| | |
|---|---|
| **Parental concerns related to client's behaviors and academic performance at school:** | |
| **If school observation is conducted,** teacher concerns related to client's behaviors and academic performance at school: | |
| **Care Coordination Involving the Caregiver(s), School, State Disability Programs and Others as Applicable** | |
| | |

| **CLINICAL INTERVIEW** | | | |
|---|---|---|---|
| **Caregiver Concerns and Priorities** | | | |
| | **Problem behaviors identified by caregiver** | **Clinical rationale if not addressed during current reporting period** | **Skill deficits identified by caregiver** |
| **FBA/Previous Report:** | | | |
| **Current Report:** | | | |

| **DIRECT ASSESSMENT PROCEDURES/PROGRESS MONITORING RESULTS** | | | |
|---|---|---|---|
| **Data Collection** | | | |
| **Dates of data collection** | **Data collection method(s)** | **Location** | **Person(s) collecting data and credentials** |
| | | | |
| **Preference Assessment (PA)** | | | |
| **Date of assessment** | **Type of PA** | **List of most preferred items** (Update every 6 months) | |
| | ☐ Survey/caregiver interview<br>☐ Paired choice<br>☐ Single Stimulus<br>☐ MSWO<br>☐ Free Operant Engagement Based | | |

| **Skills Assessment Results (e.g., VB-MAPP, Vineland, AFFLS, PEAK, etc.)** (*Updated results required **annually***) | |
|---|---|
| **Date of administration** *(required)*: | |
| *Insert test tables/visual representation of results and summary:* | |

| **TREATMENT PLAN** |
|---|
| **Skill acquisition goals:** Identify measurable goals and objectives that are specific, behaviorally defined, developmentally appropriate socially significant and based on clinical observation. Domains such as prerequisite skills, communication, daily living skills, etc.<br>***Use one box per domain*** |

| **Domain:** *(prerequisite skills, communication, daily living skills, etc.)* | |
|---|---|
| **Target Skill(s)** | |
| Baseline level of performance based on assessment criteria and clinical observation | Relative strengths:<br><br>Skill deficits: |
| **Individualized measurable goal(s) with estimated date of mastery** *(Short-term, intermediate, & long-term)* | Goal 1:<br><br>Goal 2:<br><br>Goal 3:<br><br>*(add or remove goals as needed)* |
| **Generalization criteria for goals** *(across people, settings, time)**:*** | |
| **Status:**<br>*(progress report only)* | Goal 1: ☐ In Progress/Continue ☐ On Hold/Discontinued ☐ Met<br>Goal 2: ☐ In Progress/Continue ☐ On Hold/Discontinued ☐ Met<br>Goal 3: ☐ In Progress/Continue ☐ On Hold/Discontinued ☐ Met |
| **Present level of performance per goal** *(progress summary)**:***<br><br>***Include graphs w/ 12 months of data***<br><br>*(progress reports only)* | |
| **Summary of environmental barriers that hindered meeting the goal(s) and solution**<br><br>*(progress reports only)* | |
| **Revised or newly proposed goals for next reporting period:**<br><br>*(progress reports only)* | |

| | |
|---|---|
| **Treatment Plan to address the goal(s) within domain. Evidence based BHT services with demonstrated clinical efficacy:** | *Teaching Plan:*<br>• *Teaching method:*<br>• *Prompting method:*<br>• *Program for generalization:*<br>• *Data Collection method:* |

**Behavior Reduction Goals**

- Complete one table for each problem behavior unless problem behaviors are part of a response class hierarchy
- If you are addressing multiple problem behaviors, copy and paste Target Problem Behavior table as needed

| | |
|---|---|
| **Target Problem Behavior:** | |
| **Operational Definition:** | |
| **Baseline level:** (collected by clinician, include a baseline graph) **If not observed**, please include clinical steps that will be taken once services initiate to design a function-based treatment plan. | |
| **Function Identification (*Required for all target behaviors being addressed)*:** Utilize evidence -based BHT services with demonstrated clinical efficacy to identify the function(s) of behavior **(*FA or conditional probability results - AB & BC graph based on assessor's direct observation*).** | *Insert FA graph or ABC analysis:* |
| **Behavior Reduction goal(s):** *(Short-term, intermediate, & long-term)* | |
| **Date of Introduction:** | |
| **Goal Status:** *(progress reports only)* | Goal #: ☐ In Progress/Continue ☐ On Hold/Discontinue ☐ Met |
| **Alternative Behavior goal (s):** *(Short-term, intermediate, & long-term)* | |
| **Date of Introduction:** | |
| **Goal Status:** *(progress reports only)* | Goal #: ☐ In Progress/Continue ☐ On Hold/Discontinue ☐ Met |

| | |
|---|---|
| **Generalization criteria** *(across people, settings, time)**:*** | |
| **Initial Treatment Plan:** (function based and technological) to address problem behavior(s). Evidence based BHT services with demonstrated clinical efficacy. | *Preventative Antecedent Strategies:*<br>*Teaching Strategies:*<br>*Consequence Strategies:* |
| **Present Level of Performance per goal** (progress summary):<br><br>***Include graphs w/ 12 months of data***<br><br>*(progress reports only)* | |
| **Environmental barriers that hindered meeting the goal and solution:**<br>*(progress reports only)* | |
| **Revised or New goals** *(if applicable)**:***<br><br>*(progress reports only)* | |

| **CAREGIVER/GUARDING TRAINING** |
|---|
| **Support and participation needed to achieve the goals and objectives for both member and guardian**<br>**Data/progress **required** every reporting period. If no data/progress, please include steps that will be taken to eliminate barriers the following reporting period to ensure goals are targeted.* |
| |

| **Caregiver Training:** | |
|---|---|
| **Target Skill(s)** | |
| Baseline level of performance based on clinical observation | |
| **Individualized measurable goal(s) with estimated date of mastery** *(Short-term, intermediate, & long-term)***:** | Goal 1:<br><br>Goal 2:<br><br>Goal 3: |

| | |
|---|---|
| | *(add or remove goals as needed)* |
| **Generalization Criteria for goals** *(across people, settings, time)**:*** | |
| **Status:** *(progress reports only)* | Goal 1: ☐ In Progress/Continue ☐ On Hold/Discontinued ☐ Met<br>Goal 2: ☐ In Progress/Continue ☐ On Hold/Discontinued ☐ Met<br>Goal 3: ☐ In Progress/Continue ☐ On Hold/Discontinued ☐ Met |
| **Present Level of Performance per goal** *(progress summary)**:***<br><br>***Include graphs w/ 12 months of data***<br>*(progress reports only)* | |
| **Summary of environmental barriers that hindered meeting the goal(s) and solution:** *(progress reports only)* | |
| **Revised or Newly Proposed Goals for next Reporting Period:** *(progress reports only)* | |
| **Treatment Plan to address the goal(s) within domain. Evidence based BHT services with demonstrated clinical efficacy:** | *Teaching Plan:*<br>• *Teaching method:*<br>• *Prompting method:*<br>• *Program for generalization:*<br>• *Data Collection method:* |

| **SUMMARY AND RECOMMENDATIONS** |
|---|
| Treatment Summary:<br><br>Recommendations: |
| **Rationale for Change in Clinical Recommendations** (*if different from previous reporting period*): |
| |

| | |
|---|---|
| How many goals were met in the *previous* reporting period | |
| How many goals have been met in the *current* reporting period | |
| How many goals will be targeted during the next reporting period | |
| | |
| Was the guardian involved in the development of the treatment plan? | ☐ Yes ☐ No |
| Date the treatment plan was discussed/shared with caregiver: | |
| Is the guardian in agreement with the treatment plan/recommendations? | ☐ Yes ☐ No |
| *If any of the responses were marked "No," provider explanation:* | |

## CRISIS PLAN

## TRANSITION PLAN

## DISCHARGE CRITERIA

Note: Please include the following disclaimer in your reports: The content of this report has been thoroughly discussed with client's parent(s). Parent(s) agree with assessment findings, intervention plans, goals, objectives and recommendation. If parents do not agree with any part of your report indicate which parts and the reason for disagreement.

## SIGNATURE(s)

| Qualified Autism Service Provider Signature | QASP Credentials | Date |
|---|---|---|