CATALIGHT

CARE SERVICES

# Report Authoring & Submission Guide

Effective: June 1, 2022

## Introduction

### *Introduction to the Report Authoring and Submission Guide*

Catalight Care Services (CCS) is committed to supporting Providers in delivering and documenting the highest quality of care to their clients in a consistent and efficient manner. The *Report Authoring and Submission Guide* is a tool for Providers to inform their assessment and treatment reporting in order for reports to meet funder expectations and more importantly, to clearly demonstrate to Clients and Caregivers the socially significant impact of Behavioral Health Treatment (BHT) in their individual lives.

The Guide includes references to policies, procedures, and definitions outlined in the CCS Provider Manual in the event they relate to requirements of reporting and documentation.

***Please reference the CCS Provider Manual for guidance on processes and procedures associated with report authoring, billing, and practitioner role responsibilities.***

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CARE SERVICES

Client Name:Click or tap here to enter text.
Client MRN:Click or tap here to enter text.
Date of Report: Click or tap here to enter text.

# Assessment Report

Assessment conducted in the following setting:
Choose an item.

**REQUIREMENTS OF ASSESSMENT**

- **Assessments (excluding SSG) must be conducted over a minimum of two (2) in-person (or Telehealth) appointments.**
- **SSG assessments can be conducted over one (1) in-person (or Telehealth) appointment.**
- **It is recommended that Assessments (excluding SSG) should include approximately 4-hours of face-to-face time with the client and family.**
- **SSG assessments should include at minimum 1 hour of face-to-face time with the client and family.**
- **Must include direct observations by a Qualified Autism Service Provider and should take place in a minimum of two (2) different settings that are natural environments for the client when applicable. (This is excluding SSG Assessments)**
- **Must be authored by a Qualified Autism Service Provider.**
- **If any of the above are not obtainable, please consult with your Clinical Care Team.**

| | |
|---|---|
| **Provider Name OR** | Click or tap here to enter text. |
| **Provider Logo (optional)** | |

**CLIENT INFORMATION**

| | |
|---|---|
| **Client Full Legal Name:** | Click or tap here to enter text. |
| **Client Preferred Name (if applicable)** | Click or tap here to enter text. |
| **Date of Birth:** | Click or tap to enter a date. |
| **Client Age in Years, Months:** *(e.g., 02 years, 08 months)* | Click or tap here to enter text. |
| **Client's Race / Ethnicity** **Reference clinical documents sent in BHT** | Click or tap here to enter text. |

| | |
|---|---|
| **If this was not provided, obtain information from client/family** | |
| **Client's Gender**<br>**Client's Pronouns**<br>**Reference clinical documents sent in BHT**<br>**If this was not provided, obtain information from client/family** | Choose an item.<br>Choose an item. |
| **Parent/Legal Guardian Name:** | Click or tap here to enter text. |
| **Parent/ Legal Guardian Address:** | Click or tap here to enter text. |
| **Client Resides With:**<br><br>**Client Address if Different Than Parent/Legal Guardian:** | Click or tap here to enter text.<br><br>Click or tap here to enter text. |
| **Out of (Funder) Service Area (OOSA) Yes or No:**<br>*(If Yes, provide treatment location)* | Click or tap here to enter text. |
| **Phone Number:**<br>**Indicate caregiver or client's phone number** | Click or tap here to enter text. |
| **Treatment Team:**<br>*Include contact email and phone for supervisor)*<br>**Indicate clinician who conducted the assessment** | Click or tap here to enter text. |
| **Diagnosis** (listed on authorization)**:** | Click or tap here to enter text. |
| **Diagnosing MD or Psychologist Name AND Date of Diagnosis(es)**<br>*(If not ASD Client, use the referring physician)* | Click or tap here to enter text. |
| **Projected Offer of BHT:**<br>**Date should reflect no more than 10 business days from the last appointment with client/caregiver and should not be prior to the report submission date.** | Click or tap to enter a date. |
| **Academic Performance** *(School)* | IEP? Yes ☐ No ☐ |
| | Special Education / SDC? Yes ☐ No ☐ |
| | General Education? Yes ☐ No ☐ |
| | Performance in General Education (if "yes" above): Low ☐ Moderate ☐ High ☐ |

| | |
|---|---|
| | Educational Setting:<br>Choose an item. |

**Documented Reason for Referral: (Reference clinical documents sent e.g., BHT IA, DE)**
Click or tap here to enter text.

**CCS Recommendations Based on BHT Initial Assessment:**
Choose an item.

**RECOMMENDATIONS (Proposed treatment recommendations for the upcoming authorization)**

Based on assessment, observation, and the learner profile, it has been determined that intensive services as indicted below are being recommended. Direct services will be focused on skill acquisition and behavior reduction as detailed in the report below. Additionally, natural settings will be incorporated regularly into the intervention services provided as this is critical to generalizing skills for use in real world settings. ***Authorization Request (Hours agreed to by client/family)***

**Client may be clinically recommended for Caregiver Mediated and Practitioner Mediated treatment during this authorization period; however, they do not occur at the same time. Allowing flexibility to provide care throughout the authorization period to meet treatment recommendations as defined by the assessor.**

*** Services could occur in one or all settings that are marked below***
**Any one of the marked off service locations could be clinically appropriate or could occur in one or all these settings.**
**Caregiver Mediated Treatment Option**
**The recommendation may include commencing the treatment path with caregiver training prior to practitioner mediated treatment. It could also be identified as beneficial for continuity of care in the interim based on client need.**
Choose an item.

| | | | |
|---|---|---|---|
| Direct Level Practitioner – H2019 | Direct | **0 Hours/Week** | N/A |

| | | | |
|---|---|---|---|
| ***If Applicable:*** Social Skills Group – H2014 | Direct | ___ Hours/Week | Clinic/Center ☐<br>Telehealth ☐ |
| Mid-Level Supervisor – H0032 | Direct & Indirect | ___ Hours/Month | Home ☐<br>Clinic/Center ☐<br>Community ☐<br>Telehealth ☐<br>Other Setting ☐<br>Click or tap here to enter text. |
| High Level Supervisor – H0004 | Direct & Indirect | ___ Hours/Month | Home ☐<br>Clinic/Center ☐<br>Community ☐<br>Telehealth ☐<br>Other Setting ☐<br>Click or tap here to enter text. |

**An example of Caregiver Mediated: (Parent- Led ABA & SSG)**
**Direct Level Practitioner H2019 (0 Hours/Week)**
**Social Skills Group H2014 (2 Hours/Week)**
**Mid-Level Supervisor – H0032 (10 Hours/ Month)**
**High Level Supervisor – H0004 (3Hours/ Month)**

**Practitioner Mediated Treatment Option**

Choose an item.

**Practitioner Mediated hours will begin after initial caregiver training has occurred for (#) weeks. The assessor may deem starting the authorization by focusing on caregiver training after a predetermined number of weeks, based on clinical discretion.**

**RANGE OF HOURS for Direct Level Practitioner-H2019 (GRID BELOW) reflect (Beneficial - Optimal) hours.**

**Beneficial:** Hours are based on clinical assessment and are projected to meet medical needs. Beneficial hours may necessitate decreasing the number of goals or require prioritization.

**Optimal:** Hours are based on clinical assessment and are projected to provide the most optimal client outcomes.

| Practitioner Level | Service Type | Hours | Location of Services |
|---|---|---|---|
| Direct Level Practitioner – H2019 | Direct | **Range of Hours**<br>(  ) Hours/Week | Home ☐<br>Clinic/Center ☐<br>Community ☐<br>Telehealth ☐<br>Other Setting ☐<br>Click or tap here to enter text. |
| Social Skills Group – H2014 | Direct | ___ Hours/Week | Clinic/Center ☐<br>Telehealth ☐ |
| Mid-Level Supervisor – H0032 | Direct & Indirect | ___ Hours/Month | Home ☐<br>Clinic/Center ☐<br>Community ☐<br>Telehealth ☐<br>Other Setting ☐<br>Click or tap here to enter text. |

| | | | |
|---|---|---|---|
| High Level Supervisor – H0004 | Direct & Indirect | ___ Hours/Month | Home ☐<br>Clinic/Center ☐<br>Community ☐<br>Telehealth ☐<br>Other Setting ☐<br>Click or tap here to enter text. |

**An example in which the first 4 weeks of treatment will focus on=**
**Caregiver Mediated:**
**Direct Level Practitioner H2019 (0 Hours/Week)**
Social Skills Group H2014 (0 Hours/Week)
**Mid-Level Supervisor – H0032 (10 Hours/ Month)**
**High Level Supervisor – H0004 (2 Hours/ Month)**

**Proceeded by=**
**Practitioner Mediated:**
**Direct Level Practitioner H2019 (15-20 Hours/Week)**
Social Skills Group H2014 (0 Hours/Week)
**Mid-Level Supervisor – H0032 (12Hours/ Month)**
**High Level Supervisor –H0004 (4 Hours/ Month)**

**Recommendation Rationale:**

- **When making recommendations for treatment hours, consider assessment findings, clinical judgment, family factors (e.g., family schedule) and BACB guidelines.**
- **Recommendation rationale should be specific to the individual client's treatment needs.**
- **If client lives OOSA (Out of Service Area) recommendations must be for options within the service area or Telehealth (e.g., Clinic or family member's home in the service area).**
- **If an educational setting is clinically recommended the following is needed:**
  - **Rationale for medical necessity**
  - **Coordination of care cited in below section with CCS and educational personnel**
  - **Generalization criteria needs to include educational Provider/Aide**
  - **Fade plan**
  - **Education setting should rarely be the sole location of services. If this is what is being recommended, CCS consultation is required.**

Click or tap here to enter text.

***If client is recommended for Social Skills Group, please include description of group below.***

**Social Skills Group description, if applicable:**
Choose an item.

- **Provide the type of group modality that will be provided (i.e., ABA, CBT, DBT or ACT)**
- **Of note, the same SSG type of modality does not need to be used if transferred to another provider**

**Are In-Person Services Recommended? ☐ Yes ☐ No**
**If "yes," please provide risk/benefit rationale below**
Click or tap here to enter text.
**Was an in-person service delivery attestation completed? ☐ Yes ☐ No**
**If clinic/center-based services are recommended, please provide pick-up/drop-off policy:**
Click or tap here to enter text.

**BACKGROUND AND METHODOLOGY**
This evaluation determines eligibility and recommendations for an intensive ABA program. For the purposes of this assessment, data from a variety of sources including direct observation in multiple natural settings, direct assessment using appropriate tools, interviews with caregivers, and review of previous records was utilized.

**REVIEW OF RECORDS**

**List any records pertaining to the client that were reviewed by the assessment team.**
Information contained in reports by other service providers helps to provide the assessor with a more comprehensive understanding of an individual's history and current skill levels. For the purpose of this assessment, the following documents were reviewed:

Click or tap here to enter text.

**ASSESSMENT APPOINTMENTS**

| Date | Times | Location | Assessment Methods/Tools Used | Evaluator(s) Present |
|---|---|---|---|---|
| Click or tap to enter a date. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |

| | | | | |
|---|---|---|---|---|
| Click or tap to enter a date. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap to enter a date. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |

**Did care coordination occur during this assessment period? Yes ☐ No ☐**
**If" No," Please provide reason:**
**Coordination of Care:**
***(Other Behavioral Health Treatment, supplementary services, CCS Care Team, or educational entities with which collaboration for treatment recommendations occurred within this reporting period). Note that if you recommend services in an educational setting, collaboration with CCS and school personnel needs to be included in this section.***

| Type of Collaboration/Coordination & Description | Name and/or Role | Date(s) and/or frequency of collaboration |
|---|---|---|
| | | |
| | | |
| | | |

**HISTORY & SUMMARY OF SERVICES**

**FAMILY CONSTELLATION**

**(Describe the environment in which the client lives – including family members, languages spoken, and any cultural considerations)**

Click or tap here to enter text.

**SIGNIFICANT BIRTH & MEDICAL HISTORY**

**(Include birth history & past and / or ongoing medical issues. List any reported medications)**
Click or tap here to enter text.

**EDUCATIONAL SERVICES:**

Total number of hours of education services comprised of the following:

| Service | Service Dates | Intensity (Hours Per Week/Month) |
|---|---|---|
| Click or tap here to enter text. | | Click or tap here to enter text. |
| Click or tap here to enter text. | | Click or tap here to enter text. |

**OTHER SERVICES List services the client accesses outside the educational system (e.g., other therapies, social groups, extracurricular activities, and other supplementary services not offered in the client's educational program.)**

Total number of hours of other services comprised of the following (including extracurricular activities):

| Service | Service Dates | Intensity (Hours Per Week/Month) |
|---|---|---|
| Click or tap here to enter text. | | Click or tap here to enter text. |
| Click or tap here to enter text. | | Click or tap here to enter text. |

**CURRENT LEVEL OF FUNCTIONING AND ASSESSMENT RESULTS**
**Include response to practitioners and relevant social, play, and tangible reinforcers.**

**PREFERENCE ASSESSMENT Include RAISD assessment if used.**
Click or tap here to enter text.

**BEHAVIORAL ASSESSMENT Include behavioral strengths and challenges, and functional assessment of problem behaviors.**

**Complete FBA if any one of the following factors is present:**
- **Risk of harm to self or others.**
- **Clinically significant behavior data obtained from assessment tools.**

- **Behavior excesses are not developmentally and/or socially appropriate and pose a concern to the client/others.**
- **Behavioral contract exists across caregivers.**

Click or tap here to enter text.

**ADAPTIVE BEHAVIOR ASSESSMENT**

***If Vineland-3 Update Not Completed, please provide rationale and timeline for completion:***

**(Include attempts made to complete the Vineland-3 & proposed timeline for submission.)** Click or tap here to enter text.

Vineland Adaptive Scales, 3rd edition was used to assess the individual's adaptive behavior functioning. The standard scores reported have an average of 100 and a standard deviation of 15. Age-equivalents indicate the average age of the individual from the Vineland-3 normative sample who obtained the same raw score as the individual currently being assessed. Adaptive levels are scored on a 5-point scale from Low to High.

Individuals over the age of three will include Maladaptive Behavior Index

| | |
|---|---|
| **Vineland-3 Form Used** (Comprehensive Interview Form / Comprehensive Parent Caregiver Form) | |
| **Vineland-3 Assessment Date** | Click or tap to enter a date. |
| **Name of Respondent** | |
| **Relationship of Respondent to Client** | |

***The table below is copied from Q-Global Report:***

| Domain | Standard Score | V-Scale Score | Adaptive Level | Percentile Rank | Age Equivalent |
|---|---|---|---|---|---|
| **Communication** | | | | | |
| Receptive | | | | | |
| Expressive | | | | | |
| **Daily Living Skills** | | | | | |
| Personal | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| Domestic | | | | | |
| Community | | | | | |
| **Socialization** | | | | | |
| Interpersonal Relationships | | | | | |
| Play and Leisure Time | | | | | |
| Coping Skills | | | | | |
| **Motor Skills** *(optional)* | | | | | |
| Fine Motor | | | | | |
| Gross Motor | | | | | |
| **Maladaptive Behavior (optional)** | | | | | |
| Internalizing | | | | | |
| Externalizing | | | | | |
| Other | | | | | |
| **Adaptive Behavior Composite** | | | | | |

**ASSESSMENT RESULTS Paragraph summarizing strengths and deficit areas that will be addressed in treatment.**
Click or tap here to enter text.

**SLEEP CHECKLIST**

| Checklist should be completed in collaboration with caregiver & addressed within Caregiver Training Goals | |
|---|---|
| Is sleep/bedtime a significant problem? | Choose an item.<br>If **Yes**, answer questions below |
| Goals for Sleep/Bedtime | |
| Caregiver training goals addressing sleep/bedtime | Choose an item.<br>If **No**, provide a clinical rationale:<br>Click or tap here to enter text. |
| Sleep goals addressed | ☐ Difficulty falling asleep<br>☐ Frequent waking & stays awake<br>☐ Problem behaviors associated with bedtime<br>☐ Excessive daytime sleepiness *(not associated with a medical condition)*<br>☐ Inadequate Nighttime Sleep Duration |

**Desired Outcomes of Behavioral Health Treatment for Client / Family:**

- Click or tap here to enter text.
- Click or tap here to enter text.
- Click or tap here to enter text.
- Click or tap here to enter text.

**PROPOSED GOALS**

- **Clients 12 years and older goals should focus on increasing quality of life and independence. Functional, curriculum-based programs are strongly recommended.**
- **Clients 6 and older without meaningful vocal language should focus on functional verbal behavior and socially significant behavioral skills.**

## RECEPTIVE COMMUNICATION

Skills in this domain target a client's responses to communication from others across settings, communication partners, and language functions.

**Strengths:**

**Document three strengths the child/youth currently exhibit.**

-
-

- 

1. **Treatment Goal: (within six-months)** Click or tap here to enter text.
   **Assessment Tool Source:**
   **Baseline Date and Brief Description:** Click or tap to enter a date. Click or tap here to enter text.

   **Generalization Criteria:** Choose an item.
   **If choosing Not Applicable, provide a rationale as to why it is not needed.**

**EXPRESSIVE COMMUNICATION**
Skills in this domain target a client's functional use of expressive language across settings, communication partners, and language functions.

**Strengths:**
**Document three strengths the child/youth currently exhibit.**

- 
- 
- 

2. **Treatment Goal: (within six-months)** Click or tap here to enter text.
   **Assessment Tool Source:**
   **Baseline Date and Brief Description:** Click or tap to enter a date. Click or tap here to enter text.
   **Generalization Criteria:** Choose an item.
   **If choosing Not Applicable, provide a rationale as to why it is not needed.**

**PRAGMATIC COMMUNICATION**
Skills in this domain target a client's functional use of communication, imitation, and joint attention in social environments

**Strengths:**
**Document three strengths the child/youth currently exhibit.**

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- 
- 

3. **Treatment Goal: (within six-months)** Click or tap here to enter text.
   **Assessment Tool Source:**
   **Baseline Date and Brief Description:** Click or tap to enter a date. Click or tap here to enter text.
   **Generalization Criteria:** Choose an item.

**If choosing Not Applicable, provide a rationale as to why it is not needed.**

**SELF HELP / DAILY LIVING SKILLS**

Skills in this domain focus on activities of daily living including developmentally appropriate personal independence (eating, dressing, hygiene, household responsibilities), safety, play and leisure (independent and with adult and peer partners), and community skills.

**Strengths:**

**Document three strengths the child/youth currently exhibit.**

- 
- 
- 

4. **Treatment Goal: (within six-months)** Click or tap here to enter text.
   **Assessment Tool Source:**
   **Baseline Date and Brief Description:** Click or tap to enter a date. Click or tap here to enter text.
   **Generalization Criteria:** Choose an item.
   **If choosing Not Applicable, provide a rationale as to why it is not needed.**

**BEHAVIOR**

This domain focuses on behavioral excesses and skill deficits which pose a risk to the client or others or present a clinically significant need for intervention.

**Currently Exhibits:**

**Document three strengths the child/youth currently exhibit.**

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- 
- 

5. **Treatment Goal: (within six-months)** Click or tap here to enter text.
   **Assessment Tool Source:**
   **Baseline Date and Brief Description:** Click or tap to enter a date. Click or tap here to enter text.
   **Generalization Criteria:** Choose an item.
   **If choosing Not Applicable, provide a rationale as to why it is not needed.**

**FUNCTIONAL BEHAVIOR ASSESSMENT AND BEHAVIOR PLAN (IF APPLICABLE)**

**Is physical intervention clinically indicated? ☐ Yes ☐ No**
Click or tap here to enter text.

**If physical intervention is clinically indicated, has the intervention in this treatment plan been reviewed and approved by CCS? ☐ Yes ☐ No**
Click or tap here to enter text.

**Has the intervention been reviewed with parent/caregiver/client and are they in agreement with described intervention? ☐ Yes ☐ No**
Click or tap here to enter text.

**If Dangerous Behaviors are Present, list assessment tool source(s) used**
Choose an item.

**Behavior Support Plan (if indicated):**
Click or tap here to enter text.

**BEHAVIORAL CRISIS PLAN:**
**If applicable, this is a plan agreed upon by the treatment team, client, and caregivers in the event behavioral escalation will result in imminent harm to the client and/or others or significantly threaten the safety of the client or others in the home or community.**

**This is a plan individualized to the client's identified behaviors, the environment in which the plan would need to be executed, and to the abilities of those implementing the plan.**

**If any kind of restraint is to be used as part of the plan, this should be clearly documented here along with the qualifications and training of those utilizing that intervention. Please refer and follow guidance provided in the CCS Provider Manual under *Client Restraints*.**
Click or tap here to enter text.

**CAREGIVER TRAINING**
This domain is focused on education for caregivers. Goals are developed in collaboration with the caregivers and reflect their identified needs and priorities.

**Caregiver Participation**
Compliance with treatment recommendations and active parent/caregiver participation is essential to optimal client progress in programs. Treatment aims at empowering parent(s)/caregiver(s) to independently carry over strategies to their daily lives thus enabling independence and fulfillment for the client and their family.

**Strengths:**
**Document three strengths the child/youth currently exhibit.**

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- 
- 

6. **Treatment Goal: (within six-months)** Click or tap here to enter text.
   **Assessment Tool Source:**
   **Baseline Date and Brief Description:** Click or tap to enter a date. Click or tap here to enter text.
   **Generalization Criteria:** Choose an item.
   **If choosing Not Applicable, provide a rationale as to why it is not needed.**

**SUMMARY OF ASSESSMENT RESULTS**
**Summary of Strengths**:
Click or tap here to enter text.

**Summary of Behavioral and Adaptive Concerns**:
Click or tap here to enter text.

| BARRIERS TO SERVICE | **Environmental or family concerns that are likely to have significantly impacted service delivery in the last treatment period.**<br>☐ Yes<br>☐ No<br>**Examples could include:**<br>• **Significant changes in family (e.g., divorce, remarriage, new siblings, moving, death in the family)**<br>• **Illness, mental illness, or other disabilities in the family (other than the client)** |
|---|---|

| | |
|---|---|
| | • **Socioeconomic insecurity (e.g., poverty, immigration issues, housing issues, unsafe neighborhood)**<br>• **Changes in school placement**<br>• **Home environment may be inappropriate for service delivery, or an inappropriate work environment for staff**<br><br>**If any of these factors are present and identified as having an impact on service delivery, please contact your CCS Clinical Case Manager for support.** |
| **DOES CLIENT EXHIBIT DANGEROUS BEHAVIORS (inclusive of any dangerous behaviors observed during or outside of treatment)?**<br>**☐ Yes ☐ No**<br><br>**INCLUSION OF CAREGIVER REPORT & GOAL PROGRESS**<br><br>**Dangerous behaviors are a subset of maladaptive or problem behaviors; severe behaviors that could result in physical injury requiring first aid or medical attention or behaviors that could result in law enforcement involvement.** | **If "Yes," please select all that apply:**<br>☐ **Self-injurious behavior** that could result in the need for first aid or medical attention<br>• Age or date of onset (estimated) Choose an item.. Click or tap to enter a date.<br>• Frequency: Choose an item.<br>• Intensity: Choose an item.<br>☐ **Physical harm to others** that could result in the need for first aid or medical attention<br>• Age or date of onset (estimated) Choose an item. Click or tap to enter a date.<br>• Frequency: Choose an item.<br>• Intensity: Choose an item.<br>☐ **Dangerous elopement** that is not age-appropriate and could result in injury<br>• Age or date of onset (estimated) Choose an item.. Click or tap to enter a date.<br>• Frequency: Choose an item.<br>• Intensity: Choose an item.<br>☐ **Sexually inappropriate behavior** that could result in physical harm, serious complaint from others or law enforcement involvement<br>• Age or date of onset (estimated) Choose an item. Click or tap to enter a date.<br>• Frequency: Choose an item.<br>• Intensity: Choose an item. |

| | |
|---|---|
| **Behavior Support Plan (BSP) to be implemented (see BSP above)?**<br><br>☐ **Yes** ☐ **No**<br>**If "No," Rationale:**<br><br>Click or tap here to enter text. | ☐ **Property destruction** that could result in law enforcement involvement<br>• Age or date of onset (estimated) Choose an item. Click or tap to enter a date.<br>• Frequency: Choose an item.<br>• Intensity: Choose an item.<br>☐ **Eating food or non-food items** that is not age-appropriate and could result in medical attention<br>• Age or date of onset (estimated) Choose an item. Click or tap to enter a date.<br>• Frequency: Choose an item.<br>• Intensity: Choose an item.<br>☐ **Behaviors connected to elimination** that could result in physical harm or are severely socially inappropriate<br>• Age or date of onset (estimated) Choose an item. Click or tap to enter a date.<br>• Frequency: Choose an item.<br>• Intensity: Choose an item.<br>☐ **Other** behaviors that might lead to physical harm or lead to law enforcement involvement<br>< insert description ><br>• Age or date of onset (estimated) Choose an item. Click or tap to enter a date.<br>• Frequency: Choose an item.<br>• Intensity: Choose an item. |

**EMERGENCY / CRISIS PLAN**

In the event of an unexpected crisis during sessions, treatment staff will follow the general guidelines outlined below:

- Responsible adult oversees client safety
- Treatment staff will ensure safety of self
- If the Responsible adult is unavailable or unable to help, treatment staff will assist by calling 911 if appropriate and possible
- Treatment staff will inform supervisor of the incident as soon as possible
- Immediate notification to CCS and submission of a Reportable Event Form within 1 business day of the incident

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Client Name: Click or tap here to enter text.
Client MRN: Click or tap here to enter text.
Date of Report: Click or tap here to enter text.

**ANTICIPATED DISCHARGE DATE:** Click or tap to enter a date.

**Provider should be discussing discharge from behavioral health treatment and preparing clients and caregivers for exit from services from the outset of treatment.**

| **Guidelines for Discharge from ABA Episode of Care** | |
|---|---|
| ***Discharge: Episode of Care Complete*** | ***Discharge: ABA not appropriate or no longer appropriate*** |
| ▪ Cognitive potential has been reached and no significant life interfering maladaptive behaviors are present OR<br><br>▪ The client has achieved adequate stabilization and behaviors can be managed in a less intensive treatment/environment OR<br><br>▪ The client can be treated with a less intensive level of care (e.g., community social program) OR<br><br>▪ Behavior change is meaningful and sustainable (see definition of meaningful change) OR<br><br>▪ Behavior is within normal limits when compared to peers without ASD who have a similar intellectual level | • Improvements are not maintained or generalized OR<br><br>• There is a lack of meaningful progress (e.g., no change in adaptive domains) OR<br><br>• Treatment is making the symptoms persistently worse (e.g., maladaptive behavior occurs more during ABA sessions; a trial of stopping ABA results in improved behavior) OR<br><br>• Client becomes too fatigued with school/Day Program and ABA OR<br><br>• Family members / caregivers are unable to support ABA and **no or minimal progress** has been made as a result (e.g., excess cancelations result in no progress). ***NOTE:*** *Discharge is based on progress not parent participation. Before discharge every effort should be made to support family/parents so that ABA can continue* OR<br><br>• Client is 12 or older and has the ability to decline ABA (e.g., is able to express their desire to stop ABA) OR<br><br>• Behavior is more related to non-ASD mental health symptoms such as an anxiety disorder |

| **Treatment Plan Review Date with Family:**<br>(Provider met with client/family to provide update and obtain their input on treatment)<br>*NOTE: Ensure client/family is provided a copy of this report following its authorization.* | |
|---|---|
| **Report Reviewed with Client/Family?** | Yes ☐ Click or tap to enter a date. |
| | No ☐ Reason: Click or tap here to enter text. |

**PROGRAM DESCRIPTION**

Behavioral health services are designed to treat deficits associated with autism spectrum disorder and other developmental disorders. Behavioral health services help increase a person's functional skills and address behavior concerns that pose a threat to safety or independence. As much as possible treatment should occur in natural settings.

Treatment recommendations are made in partnership with clients and caregivers. Clients and caregivers should be able to review the assessment findings and the treatment goals in this report. A client's progress in treatment is measured by progress toward goals and the client's ability to function in their natural settings.

Discharge will be recommended based on the Guidelines for Discharge. Referral to other services may be suggested by the client's Clinical Case Manager.

Please contact your treatment team or **CCS Clinical Case Manager** at 855-843-2476 directly with any additional questions or comments related to this report.

Respectfully Submitted,

| | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap to enter a date. |
|---|---|---|---|
| Signature | Print Name and Title | License/Cert.# | Date<br>This date should match the date in the header. |
| | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap to enter a date. |
| Signature | Print Name and Title | License/Cert.# | Date |

CATALIGHT
CARE SERVICES

Client Name:Click or tap here to enter text.
Client MRN:Click or tap here to enter text.
Date of Report: Click or tap here to enter text.

# Progress Report

Choose an item.

Choose an item.

| | |
|---|---|
| **Provider Name OR** | Click or tap here to enter text. |
| **Provider Logo (optional)** | |

**CLIENT INFORMATION**

| | |
|---|---|
| **Client Full Legal Name:** | Click or tap here to enter text. |
| **Client Preferred Name (if applicable)** | Click or tap here to enter text. |
| **Date of Birth:** | Click or tap to enter a date. |
| **Client Age in Years, Months:**<br>*(e.g., 02 years, 08 months)* | Click or tap here to enter text. |
| **Client's Race / Ethnicity**<br>**Reference clinical documents sent in BHT**<br>**If this was not provided, obtain information from client/family** | Click or tap here to enter text. |
| **Client's Gender**<br>**Client's Pronouns**<br>**Reference clinical documents sent in BHT**<br>**If this was not provided, obtain information from client/family** | Choose an item.<br>Choose an item. |
| **Parent/Legal Guardian Name:** | Click or tap here to enter text. |
| **Parent/ Legal Guardian Address:** | Click or tap here to enter text. |
| **Client Resides With:**<br><br>**Client Address if Different Than Parent/Legal Guardian:** | Click or tap here to enter text.<br><br>Click or tap here to enter text. |
| **Out of (Funder) Service Area (OOSA) Yes or No:**<br>*(If Yes, provide treatment location)* | Click or tap here to enter text. |
| **Phone Number:** | Click or tap here to enter text. |

| | |
|---|---|
| **Indicate caregiver or client's phone number** | |
| **Treatment Team:**<br>*Include contact email and phone for supervisor)*<br>**Indicate name/s & credentials of the entire treatment team (i.e., high level supervisor, mid-level supervisor, behavior technician/s)** | Click or tap here to enter text. |
| **Diagnosis** (listed on authorization)**:** | Click or tap here to enter text. |
| **Diagnosing MD or Psychologist Name AND Date of Diagnosis(es)**<br>*(If not ASD Client, use the referring physician)* | Click or tap here to enter text. |
| **Initial BHT Start Date:**<br>**Date reflective of client's complete episode of care.** | Click or tap to enter a date. |
| **Academic Performance** *(School)* | IEP? Yes ☐ No ☐ |
| | Special Education / SDC? Yes ☐ No ☐ |
| | General Education? Yes ☐ No ☐ |
| | Performance in General Education (if "yes" above): Low ☐ Moderate ☐ High ☐ |
| | Educational Setting:<br>Choose an item. |

**Documented Reason for Referral: (Reference clinical documents sent e.g., BHT IA, DE)**
Click or tap here to enter text.

**RECOMMENDATIONS (Proposed Treatment Recommendations for the upcoming authorization)**
Based on assessment, observation, and the learner profile, it has been determined that intensive services as indicted below are being recommended. Direct services will be focused on skill acquisition and behavior reduction as detailed in the report below. Additionally, natural settings will be incorporated regularly into the intervention services provided as this is critical to generalizing skills for use in real world settings.

***Authorization Request (Hours agreed to by client/family)***

**Client may be clinically recommended for Caregiver Mediated and Practitioner Mediated treatment during this authorization period; however, they do not occur at the same time. Allowing flexibility to provide care throughout the authorization period to meet the beneficial treatment recommendations as defined by the assessor.**

*** Services could occur in one or all settings that are marked below***
**Any one of the marked off service locations could be clinically appropriate or could occur in one or all these settings.**

**Caregiver Mediated Treatment Option**
Choose an item.

| | | | |
|---|---|---|---|
| Direct Level Practitioner – H2019 | Direct | **0 Hours/Week** | N/A |
| ***If Applicable:*** Social Skills Group – H2014 | Direct | ___ Hours/Week | Clinic/Center ☐ Telehealth ☐ |
| Mid-Level Supervisor – H0032 | Direct & Indirect | ___ Hours/Month | Home ☐ Clinic/Center ☐ Community ☐ Telehealth ☐ Other Setting ☐ Click or tap here to enter text. |
| High Level Supervisor – H0004 | Direct & Indirect | ___ Hours/Month | Home ☐ Clinic/Center ☐ Community ☐ Telehealth ☐ Other Setting ☐ Click or tap here to enter text. |

**An example of Caregiver Mediated: (Parent-Led ABA& SSG)**
**Direct Level Practitioner H2019 (0 Hours/Week)**
**Social Skills Group H2014 (2 Hours/Week)**
**Mid-Level Supervisor – H0032 (10 Hours/ Month)**
**High Level Supervisor – H0004 (3 Hours/ Month)**

**Practitioner Mediated Treatment Option**
Choose an item.

**RANGE OF HOURS for Direct Level Practitioner-H2019(GRID BELOW) reflect (Beneficial- Optimal) hours.**

**Beneficial:** Hours are based on clinical assessment and are projected to meet medical needs. Beneficial hours may necessitate decreasing the number of goals or require prioritization.

**Optimal:** Hours are based on clinical assessment and are projected to provide the most optimal client outcomes.

| Practitioner Level | Service Type | Hours | Location of Services |
|---|---|---|---|
| Direct Level Practitioner – H2019 | Direct | **Range of Hours**<br>( - ) Hours/Week | Home ☐<br>Clinic/Center ☐<br>Community ☐<br>Telehealth ☐<br>Other Setting ☐<br>Click or tap here to enter text. |
| Social Skills Group – H2014 | Direct | ___ Hours/Week | Clinic/Center ☐<br>Telehealth ☐ |
| Mid-Level Supervisor – H0032 | Direct & Indirect | ___ Hours/Month | Home ☐<br>Clinic/Center ☐<br>Community ☐<br>Telehealth ☐<br>Other Setting ☐<br>Click or tap here to enter text. |

| | | | |
|---|---|---|---|
| High Level Supervisor – H0004 | Direct & Indirect | ___ Hours/Month | Home ☐<br>Clinic/Center ☐<br>Community ☐<br>Telehealth ☐<br>Other Setting ☐<br>Click or tap here to enter text. |

**An example of selecting Caregiver & Practitioner Mediated options to allow for flexibility within the authorization period-**
**Caregiver Mediated:**
**Direct Level Practitioner H2019 (0 Hours/Week)**
Social Skills Group H2014 (0 Hours/Week)
**Mid-Level Supervisor – H0032 (10 Hours/ Month)**
**High Level Supervisor – H0004 (2 Hours/ Month)**
**Practitioner Mediated:**
**Direct Level Practitioner H2019 (15-20 Hours/Week)**
Social Skills Group H2014 (0 Hours/Week)
**Mid-Level Supervisor – H0032 (12Hours/ Month)**
**High Level Supervisor –H0004 (4 Hours/ Month)**

**Recommendation Rationale:**

- **When making recommendations for treatment hours, consider assessment findings, clinical judgment, family factors (e.g., family schedule) and BACB guidelines.**
- **Recommendation rationale should be specific to the individual client's treatment needs.**
- **If client lives OOSA (Out of Service Area) recommendations must be for options within the service area or Telehealth (e.g., Clinic or family member's home in the service area).**
- **If an educational setting is clinically recommended the following is needed:**
  - **Rationale for medical necessity**
  - **Coordination of care cited in below section with the CCS and educational personnel**
  - **Generalization criteria needs to include educational Provider/Aide**
  - **Fade Plan**
  - **Education setting should rarely be the sole location of services. If this is what is being recommended, CCS consultation is required.**

Click or tap here to enter text.

CATALIGHT
CARE SERVICES

Client Name: Click or tap here to enter text.
Client MRN: Click or tap here to enter text.
Date of Report: Click or tap here to enter text.

**Are In-Person Services Recommended? ☐ Yes ☐ No**

**If "yes," please provide risk/benefit rationale below:**
Click or tap here to enter text.

**Was an in-person service delivery attestation completed since last report submission?**
**☐ Yes ☐ No**

**If clinic/center-based services are recommended, please provide pick-up/drop-off policy:**
Click or tap here to enter text.

**CURRENT AUTHORIZATION**

| **Current Authorization Treatment Start / End Date:** Click or tap to enter a date. - Click or tap to enter a date. | |
|---|---|
| **Service** | **Hours** |
| Direct Service Practitioner – H2019 (weekly) | **Range of Hours**<br>( - ) Hours/Week |
| Social Skills Group – H2014 (only if part of treatment plan with ABA) (weekly) | ____ Hours/Week |
| Mid-Level Supervisor– H0032 (monthly) | ____ Hours/Month |
| High-Level Supervisor– H0004 (monthly) | ____ Hours/Month |

| **Average Hours Provided for This Authorization Period** | |
|---|---|
| **Service** | **Hours** |
| Direct Service Practitioner – H2019 (weekly) | ____ Hours/Week |
| Social Skills Group – H2014 (weekly) | ____ Hours/Week |

| | |
|---|---|
| Mid-Level Supervisor– H0032 (monthly) | ___ Hours/Month |
| High-Level Supervisor– H0004 (monthly) | ___ Hours/Month |

**SERVICE DELIVERY**

**Include issues related to service delivery:**

- **Explain discrepancies in hours authorized and hours used.**
- **Breaks in service and the reason.**
- **Any cultural and/or environmental considerations relevant to treatment.**

**There was a Gap in direct treatment services (If yes, provide a rationale below)**

**A Gap in direct treatment is defined as services (i.e., H2019/H0032/H0004) were not provided for more than 10 business days.**

Choose an item.
Click or tap here to enter text.

**A Gap in direct treatment services occurred, client/ caregiver was offered an appointment every 10 business days. (If no, provide a rationale below)**

**Direct treatment offers could be provided at any level of service authorized (i.e., H0032/H0004/ H2019). Documentation of offers are required. For more information on documentation requirements, reference provider manual.**

Choose an item.
Click or tap here to enter text.

**Social Skills Group description, if applicable:**

Choose an item.

- **Provide the type of group modality that will be provided (i.e., ABA, CBT, DBT or ACT)**
- **Of note, the same SSG type of modality does not need to be used if transferred to another provider**

**EDUCATIONAL SERVICES:**

Total number of hours of education services comprised of the following:

| Service | Service Dates | Intensity (Hours Per Week/Month) |
|---|---|---|

| | | |
|---|---|---|
| Click or tap here to enter text. | | Click or tap here to enter text. |
| Click or tap here to enter text. | | Click or tap here to enter text. |

**OTHER SERVICES** **List services the client accesses outside the educational system (e.g., other therapies, social groups, extracurricular activities, and other supplementary services not offered in the client's educational program.)**
Total number of hours of other services comprised of the following (including extracurricular activities):

| Service | Service Dates | Intensity (Hours Per Week/Month) |
|---|---|---|
| Click or tap here to enter text. | | Click or tap here to enter text. |
| Click or tap here to enter text. | | Click or tap here to enter text. |

**Did care coordination occur during this authorization period? Yes ☐ No ☐**
**If" No,", Please provide reason:** Choose an item.

**Coordination of Care:**
***(Other Behavioral Health Treatment, supplementary services, CCS Care Team, or educational entities with which collaboration for treatment recommendations occurred within this reporting period). Note that if you recommend services in an educational setting, collaboration with the CCS and school personnel needs to be included in this section.***

| Type of Collaboration/Coordination & Description | Name and/or Role | Date(s) and/or frequency of Collaboration |
|---|---|---|
| Choose an item. Click or tap here to enter text. | | Click or tap to enter a date. |
| Choose an item. Click or tap here to enter text. | | Click or tap to enter a date. |
| Choose an item.. Click or tap here to enter text. | | Click or tap to enter a date. |

| | | |
|---|---|---|
| Choose an item.. Click or tap here to enter text. | | Click or tap to enter a date. |

**ADAPTIVE BEHAVIOR ASSESSMENT**
***If Vineland-3 Update Not Completed, please provide rationale and timeline for completion:***
**(Include attempts to made to complete the Vineland-3 & proposed timeline for submission.)** Click or tap here to enter text.
Vineland Adaptive Scales, 3rd edition was used to assess the individual's adaptive behavior functioning. The standard scores reported have an average of 100 and a standard deviation of 15. Age-equivalents indicate the average age of the individual from the Vineland-3 normative sample who obtained the same raw score as the individual currently being assessed. Adaptive levels are scored on a 5-point scale from Low to High.

Individuals over the age of three will include Maladaptive Behavior Index (MBI).

| | |
|---|---|
| **Vineland-3 Form Used** (Comprehensive Interview Form / Comprehensive Parent Caregiver Form) | |
| **Vineland-3 Assessment Date** | Click or tap to enter a date. |
| **Name of Respondent** | |
| **Relationship of Respondent to Client** | |

***The table below is copied from Q-Global Report:***

| Domain | Standard Score | V-Scale Score | Adaptive Level | Percentile Rank | Age Equivalent |
|---|---|---|---|---|---|
| **Communication** | | | | | |
| Receptive | | | | | |
| Expressive | | | | | |
| **Daily Living Skills** | | | | | |
| Personal | | | | | |
| Domestic | | | | | |
| Community | | | | | |
| **Socialization** | | | | | |
| Interpersonal Relationships | | | | | |
| Play and Leisure Time | | | | | |
| Coping Skills | | | | | |
| **Maladaptive Behavior (optional)** | | | | | |
| Internalizing | | | | | |
| Externalizing | | | | | |
| Other | | | | | |
| **Adaptive Behavior Composite** | | | | | |

**ASSESSMENT RESULTS**

**Include a paragraph summarizing strengths and deficit areas that will be addressed in treatment.**

Click or tap here to enter text.

CATALIGHT
CARE SERVICES

Client Name: Click or tap here to enter text.
Client MRN: Click or tap here to enter text.
Date of Report: Click or tap here to enter text.

| **SLEEP CHECKLIST**<br>**Inclusion of Caregiver Report & Progress on Sleep Goals** | |
|---|---|
| Is sleep/bedtime a significant problem? | Choose an item.<br>If **Yes**, answer questions below |
| Goals for Sleep/Bedtime | |
| Caregiver training goals addressing sleep/bedtime | Choose an item.<br>If **No**, provide a clinical rationale:<br>Click or tap here to enter text. |
| Progress<br>**Reporting on progress relates directly to caregiver training goals.**<br>**Improved= Gains made from Baseline measure**<br>**No Change= Equivalent to Baseline measure**<br>**Worse= Regression from Baseline measure.**<br>**No Longer Present= No longer an area of concern** | |
| Difficulty falling asleep | Choose an item. |
| Frequent waking & stays awake | Choose an item. |
| Problem behaviors associated with bedtime | Choose an item. |
| Excessive daytime sleepiness (*Not associated with a medical condition*) | Choose an item. |
| Inadequate Nighttime Sleep Duration | Choose an item. |

**Client Strengths:**

- Click or tap here to enter text.
- Click or tap here to enter text.
- Click or tap here to enter text.
- Click or tap here to enter text.

**Desired Outcomes of Behavioral Health Treatment for Client / Family:**

- Click or tap here to enter text.
- Click or tap here to enter text.
- Click or tap here to enter text.
- Click or tap here to enter text.

CATALIGHT
CARE SERVICES

Client Name:Click or tap here to enter text.
Client MRN:Click or tap here to enter text.
Date of Report: Click or tap here to enter text.

**PROGRESS REPORT & TREATMENT PLAN**

- **Clients 12 years and older goals should focus on increasing quality of life and independence. Functional, curriculum-based programs are strongly recommended.**
- **Clients 6 and older without meaningful vocal language should focus on functional verbal behavior and socially significant behavioral skills.**

Below is the treatment plan for intervention and provider's report on progress toward goal mastery. Treatment plans are based on ongoing assessment, response to treatment, priorities of the individual, and input from other professionals that support the family.

**RECEPTIVE COMMUNICATION**

Skills in this domain target a client's responses to communication from others across settings, communication partners, and language functions.

1. **Treatment Goal: (within six-months)** Click or tap here to enter text.
   **Goal Status:** Choose an item.
   **Assessment Tool Source:**
   **Baseline Date and Brief Description:** Click or tap to enter a date. Click or tap here to enter text.
   **Generalization Criteria:** Choose an item.
   **If choosing Not Applicable, provide a rationale as to why it is not needed.**
   **Goal Attainment Scale Score:** Choose an item.
   **Progress:**
   Click or tap here to enter text.

   **Graphic Display: Strongly Recommended**
   **(Line graph, bar graph, table, cumulative graph used to evaluate progress during treatment)**

**EXPRESSIVE COMMUNICATION**

Skills in this domain target a client's functional use of expressive language across settings, communication partners, and language functions.

2. **Treatment Goal: (within six-months)** Click or tap here to enter text.
   **Goal Status:** Choose an item.
   **Assessment Tool Source:**
   **Baseline Date and Brief Description:** Click or tap to enter a date. Click or tap here to enter text.
   **Generalization Criteria:** Choose an item.
   **If choosing Not Applicable, provide a rationale as to why it is not needed.**
   **Goal Attainment Scale Score:** Choose an item.
   **Progress:**

Click or tap here to enter text.

**Graphic Display: Strongly Recommended**
**(Line graph, bar graph, table, cumulative graph used to evaluate progress during treatment)**

**PRAGMATIC COMMUNICATION**

Skills in this domain target a client's functional use of communication, imitation, and joint attention in interaction with others and in social environments

3. **Treatment Goal: (within six-months)** Click or tap here to enter text.
   **Goal Status:** Choose an item.
   **Assessment Tool Source:**
   **Baseline Date and Brief Description:** Click or tap to enter a date. Click or tap here to enter text.
   **Generalization Criteria:** Choose an item.
   **If choosing Not Applicable, provide a rationale as to why it is not needed.**
   **Goal Attainment Scale Score:** Choose an item.
   **Progress:**
   Click or tap here to enter text.

   **Graphic Display: Strongly Recommended**
   **(Line graph, bar graph, table, cumulative graph used to evaluate progress during treatment)**

**SELF HELP / DAILY LIVING SKILLS**

Skills in this domain focus on activities of daily living including developmentally appropriate personal independence (eating, dressing, hygiene, household responsibilities), safety, play and leisure (independent and with adult and peer partners), and community skills.

4. **Treatment Goal: (within six-months)** Click or tap here to enter text.
   **Goal Status:** Choose an item.
   **Assessment Tool Source:**
   **Baseline Date and Brief Description:** Click or tap to enter a date. Click or tap here to enter text.
   **Generalization Criteria:** Choose an item.
   **If choosing Not Applicable, provide a rationale as to why it is not needed.**
   **Goal Attainment Scale Score:** Choose an item.
   **Progress:**
   Click or tap here to enter text.

   **Graphic Display: Strongly Recommended**

**(Line graph, bar graph, table, cumulative graph used to evaluate progress during treatment)**

**BEHAVIOR**

This domain focuses on behavioral excesses and skill deficits, which pose a risk to the client or others, or present a clinically significant need for intervention.

5. **Treatment Goal: (within six-months)** Click or tap here to enter text.
   **Goal Status:** Choose an item.
   **Assessment Tool Source:**
   **Baseline Date and Brief Description:** Click or tap to enter a date. Click or tap here to enter text.
   **Generalization Criteria:** Choose an item.
   **If choosing Not Applicable, provide a rationale as to why it is not needed.**
   **Goal Attainment Scale Score:** Choose an item.
   **Progress:**
   Click or tap here to enter text.

   **Graphic Display: Strongly Recommended**
   **(Line graph, bar graph, table, cumulative graph used to evaluate progress during treatment)**

**FUNCTIONAL BEHAVIOR ASSESSMENT AND BEHAVIOR PLAN (IF APPLICABLE)**

**Complete FBA if any one of the following factors is present:**

- **Risk of harm to self or others**
- **Clinically significant behavior data obtained from assessment tools**
- **Behavior excesses are not developmentally and/or socially appropriate and pose a concern to the client/others**
- **Behavioral contract exists across caregiver's environments or there is a history of clinically significant behavior excesses**

**If there has been an FBA conducted for this client and a Behavior Intervention Plan (BIP) created, please include here.**

**Is physical intervention clinically indicated? ☐ Yes ☐ No**
Click or tap here to enter text.

**If physical intervention is clinically indicated, has the intervention in this treatment plan been reviewed and approved by CCS? ☐ Yes ☐ No**
Click or tap here to enter text.

**Has the intervention been reviewed with parent/caregiver/client and are they in agreement with described intervention? ☐ Yes ☐ No**
Click or tap here to enter text.

**If Dangerous Behaviors are Present, list assessment tool source(s) used**
Choose an item.

**Behavior Support Plan (if indicated):**

Click or tap here to enter text.

**BEHAVIORAL CRISIS PLAN:**
**If applicable, this is a plan agreed upon by the treatment team, client, and caregivers in the event behavioral escalation will result in imminent harm to the client and/or others or significantly threaten the safety of the client or others in the home or community.**

**This is a plan individualized to the client's identified behaviors, the environment in which the plan would need to be executed, and to the abilities of those implementing the plan.**

**If any kind of restraint is to be used as part of the plan, this should be clearly documented here along with the qualifications and training of those utilizing that intervention. Please refer and follow guidance provided in the CCS Provider Manual under *Client Restraints.***

Click or tap here to enter text.

**CAREGIVER TRAINING**
This domain is focused on education for caregivers. Goals are developed in collaboration with the caregivers and reflect their identified needs and priorities.

**Caregiver Participation**
Compliance with treatment recommendations and active parent/caregiver participation is essential to optimal client progress in programs. Treatment aims at empowering parent(s)/caregiver(s) to independently carry over strategies to their daily lives thus enabling independence and fulfillment for the client and their family.

6. **Treatment Goal: (within six-months)** Click or tap here to enter text.
   **Goal Status:** Choose an item.
   **Assessment Tool Source:**

**Baseline Date and Brief Description:** Click or tap to enter a date. Click or tap here to enter text.
**Generalization Criteria:** Choose an item.
**If choosing Not Applicable, provide a rationale as to why it is not needed.**
**Goal Attainment Scale Score:** Choose an item.
**Progress:**
Click or tap here to enter text.

**Graphic Display:** **Strongly Recommended**
**(Line graph, bar graph, table, cumulative graph used to evaluate progress during treatment)**

**SUMMARY**

**SUMMARY OF PROGRESS**
Click or tap here to enter text.

| | |
|---|---|
| **BARRIERS TO SERVICE** | **Environmental or family concerns that are likely to have significantly impacted service delivery in the last treatment period.**<br>☐ Yes<br>☐ No<br>**Examples could include:**<br>• **Significant changes in family (e.g., divorce, remarriage, new siblings, moving, death in the family)**<br>• **Illness, mental illness, or other disabilities in the family (other than the client)**<br>• **Socioeconomic insecurity (e.g., poverty, immigration issues, housing issues, unsafe neighborhood)**<br>• **Changes in school placement**<br>• **Home environment may be inappropriate for service delivery, or an inappropriate work environment for staff** |

| | **If any of these factors are present and identified as having an impact on service delivery, please contact your CCS Clinical Case Manager for support.** |
|---|---|
| **DOES CLIENT EXHIBIT DANGEROUS BEHAVIORS (inclusive of any dangerous behaviors observed during or outside of treatment)?**<br>**☐ Yes ☐ No**<br><br>**INCLUSION OF CAREGIVER REPORT & GOAL PROGRESS**<br><br>**Dangerous behaviors are a subset of maladaptive or problem behaviors; severe behaviors that could result in physical injury requiring first aid or medical attention or behaviors that could result in law enforcement involvement.**<br><br>**Behavior Support Plan (BSP) to be implemented (see BSP above)?**<br><br>**☐ Yes ☐ No**<br>**If "No," Rationale:**<br><br>Click or tap here to enter text. | **If "Yes," please select all that apply:**<br>☐ **Self-injurious behavior** that could result in the need for first aid or medical attention<br>• Age or date of onset (estimated) Choose an item. Click or tap to enter a date.<br>• Frequency: Choose an item.<br>• Intensity: Choose an item.<br>☐ **Physical harm to others** that could result in the need for first aid or medical attention<br>• Age or date of onset (estimated) Choose an item.. Click or tap to enter a date.<br>• Frequency: Choose an item.<br>• Intensity: Choose an item.<br>☐ **Dangerous elopement** that is not age-appropriate and could result in injury<br>• Age or date of onset (estimated) Choose an item. Click or tap to enter a date.<br>• Frequency: Choose an item.<br>• Intensity: Choose an item.<br>☐ **Sexually inappropriate behavior** that could result in physical harm, serious complaint from others or law enforcement involvement<br>• Age or date of onset (estimated) Choose an item. Click or tap to enter a date.<br>• Frequency: Choose an item.<br>• Intensity: Choose an item.<br>☐ **Property destruction** that could result in law enforcement involvement<br>• Age or date of onset (estimated) Choose an item.. Click or tap to enter a date.<br>• Frequency: Choose an item.<br>• Intensity: Choose an item.<br>☐ **Eating food or non-food items** that is not age-appropriate and could result in medical attention |

| | |
|---|---|
| | • Age or date of onset (estimated) Choose an item. Click or tap to enter a date.<br>• Frequency: Choose an item.<br>• Intensity: Choose an item.<br>☐ **Behaviors connected to elimination** that could result in physical harm or are severely socially inappropriate<br>• Age or date of onset (estimated) Choose an item. Click or tap to enter a date.<br>• Frequency: Choose an item.<br>• Intensity: Choose an item.<br>☐ **Other** behaviors that might lead to physical harm or lead to law enforcement involvement<br>< insert description ><br>• Age or date of onset (estimated) Choose an item. Click or tap to enter a date.<br>• Frequency: Choose an item.<br>• Intensity: Choose an item. |

**EMERGENCY / CRISIS PLAN**

In the event of an unexpected crisis during sessions, treatment staff will follow the general guidelines outlined below:

- Responsible adult oversees client safety
- Treatment staff will ensure safety of self
- If the Responsible adult is unavailable or unable to help, treatment staff will assist by calling 911 if appropriate and possible
- Treatment staff will inform supervisor of the incident as soon as possible
- Immediate notification to CCS and submission of a Reportable Event Form within 1 business day of the incident

**GOAL ATTAINMENT SCALE OVERALL PROGRESS**

| ***Includes acquisition, behavior reduction & caregiver training goals.**<br><br>**Do not include goals that are new, on hold or discontinued.** | **Total Number of Goals for Client & Caregiver** |
|---|---|
| Goals at 0 (Not Met - No Progress within Reporting Period) | |
| Goals at 1 (Not Met - Some Progress within Reporting Period) | |

| | |
|---|---|
| Goals at 2 (Goal Met - Expected outcome) | |
| Goals at 3 (Goal Met - Somewhat more than expected outcome) | |
| Goals at 4 (Goal Met - Much more than expected outcome) | |
| Total Goals Met Score (add goals scored 2, 3, & 4 on GAS) | |
| Total Percentage of Goals Met (total goals met divided by ALL goals listed above) | |

**TOTAL GOALS CLIENT & CAREGIVER**

| | |
|---|---|
| **Total Goals: met, continued, revised, on hold or discontinued** | |
| **Count of New Goals Added for Next Reporting Period** | |

**ANTICIPATED DISCHARGE DATE:** Click or tap to enter a date.

**FADE PLAN *(required if anticipated discharge date is within 6 months):***

Click or tap here to enter text. **Provide a client specific fade plan which could include:**

- **Breakdown of how hours and/or the service line/s will adjust over the next 6 months**
- **Increased caregiver participation as services fade.**
- **Clear and measurable objectives**

**ANTICIPATED DISCHARGE DATE CHANGED SINCE LAST REPORT? Yes ☐ NO ☐REASON FOR CHANGE:** Click or tap here to enter text.

| **Guidelines for Discharge from ABA Episode of Care** | |
|---|---|
| ***Discharge: Episode of Care Complete*** | ***Discharge: ABA not appropriate or no longer appropriate*** |
| ▪ Cognitive potential has been reached and no significant life interfering maladaptive behaviors are present OR<br><br>▪ The client has achieved adequate stabilization and behaviors can be managed in a less intensive treatment/environment OR<br><br>▪ The client can be treated with a less intensive level of care (e.g., community social program) OR | • Improvements are not maintained or generalized OR<br><br>• There is a lack of meaningful progress (e.g., no change in adaptive domains) OR<br><br>• Treatment is making the symptoms persistently worse (e.g., maladaptive behavior occurs more during ABA sessions; a trial of stopping ABA results in improved behavior) OR<br><br>• Client becomes too fatigued with school/Day Program and ABA OR |

| | |
|---|---|
| ▪ Behavior change is meaningful and sustainable (see definition of meaningful change) OR<br><br>▪ Behavior is within normal limits when compared to peers without ASD who have a similar intellectual level | • Family members / caregivers are unable to support ABA and **no or minimal progress** has been made as a result (e.g., excess cancelations result in no progress). ***NOTE:*** *Discharge is based on progress not parent participation. Before discharge every effort should be made to support family/parents so that ABA can continue* OR<br><br>• Client is 12 or older and has the ability to decline ABA (e.g., is able to express their desire to stop ABA) OR<br><br>• Behavior is more related to non-ASD mental health symptoms such as an anxiety disorder |

| **Treatment Plan Review Date with Family:**<br>(Provider met with client/family to provide update and obtain their input on treatment)<br>*NOTE: Ensure client/family is provided a copy of this report following its authorization.* | |
|---|---|
| **Report Reviewed with Client/Family?** | Yes ☐ Click or tap to enter a date. |
| | No ☐ Reason: Click or tap here to enter text. |

**Please contact us or your CCS Clinical Case Manager at 855-843-2476 directly with any additional questions or comments related to this report.**

Respectfully Submitted,

| | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap to enter a date. |
|---|---|---|---|
| Signature | Print Name and Title | License/Cert.# | Date<br>This date should match the date in the header. |
| | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap to enter a date. |
| Signature | Print Name and Title | License/Cert.# | Date |

CATALIGHT
CARE SERVICES

Client Name:Click or tap here to enter text.
Client MRN:Click or tap here to enter text.
Date of Report: Click or tap here to enter text.

# Discharge / Transfer Report

Choose an item.
Choose an item.

| | |
|---|---|
| **Provider Name OR** | Click or tap here to enter text. |
| **Provider Logo (optional)** | |

**CLIENT INFORMATION**

| | |
|---|---|
| **Client Full Legal Name:** | Click or tap here to enter text. |
| **Client Preferred Name (if applicable)** | Click or tap here to enter text. |
| **Date of Birth:** | Click or tap to enter a date. |
| **Client Age in Years, Months:**<br>*(e.g., 02 years, 08 months)* | Click or tap here to enter text. |
| **Client's Race / Ethnicity**<br>**Reference clinical documents sent in BHT**<br>**If this was not provided, obtain information from client/family** | Click or tap here to enter text. |
| **Client's Gender**<br>**Client's Pronouns**<br>**Reference clinical documents sent in BHT**<br>**If this was not provided, obtain information from client/family** | Choose an item.<br>Choose an item. |
| **Parent/Legal Guardian Name:** | Click or tap here to enter text. |
| **Parent/ Legal Guardian Address:** | Click or tap here to enter text. |
| **Client Resides With:**<br><br>**Client Address if Different Than Parent/Legal Guardian:** | Click or tap here to enter text.<br><br>Click or tap here to enter text. |
| **Out of (Funder) Service Area (OOSA) Yes or No:**<br>*(If Yes, provide treatment location)* | Click or tap here to enter text. |
| **Phone Number:** | Click or tap here to enter text. |

| | |
|---|---|
| **Indicate caregiver or client's phone number** | |
| **Treatment Team:**<br>*Include contact email and phone for supervisor)*<br>**Indicate name/s & credentials of the entire treatment team (i.e., high level supervisor, mid-level supervisor, behavior technician/s)** | Click or tap here to enter text. |
| **Diagnosis** (listed on authorization)**:** | Click or tap here to enter text. |
| **Diagnosing MD or Psychologist Name AND Date of Diagnosis(es)**<br>*(If not ASD Client, use the referring physician)* | Click or tap here to enter text. |
| **Initial BHT Start Date:** | Click or tap to enter a date. |
| **Academic Performance** *(School)* | IEP? Yes ☐ No ☐ |
| | Special Education / SDC? Yes ☐ No ☐ |
| | General Education? Yes ☐ No ☐ |
| | Performance in General Education (if "yes" above): Low ☐ Moderate ☐ High ☐ |
| | Educational Setting:<br>Choose an item. |

**Documented Reason for Referral:**
Click or tap here to enter text.

**RECOMMENDATIONS**
Based on assessment, observation, and the learner profile, it has been determined that intensive services as indicted below are being recommended. Direct services will be focused on skill acquisition and behavior reduction as detailed in the report below. Additionally, natural settings will be incorporated regularly into the intervention services provided as this is critical to generalizing skills for use in real world settings.

***Authorization Request (Hours agreed to by client/family)***

**Client may be clinically recommended for Caregiver Mediated and Practitioner Mediated treatment during this authorization period; however, they do not occur at the same time. Allowing flexibility to provide care throughout the authorization period to meet the beneficial treatment recommendations as defined by the assessor.**

*** Services could occur in one or all settings that are marked below***
**Any one of the marked off service locations could be clinically appropriate or could occur in one or all these settings.**
**Caregiver Mediated Treatment Option**
Choose an item.

| | | | |
|---|---|---|---|
| Direct Level Practitioner – H2019 | Direct | **0 Hours/Week** | N/A |
| ***If Applicable:*** Social Skills Group – H2014 | Direct | ___ Hours/Week | Clinic/Center ☐ Telehealth ☐ |
| Mid-Level Supervisor – H0032 | Direct & Indirect | ___ Hours/Month | Home ☐ Clinic/Center ☐ Community ☐ Telehealth ☐ Other Setting ☐ Click or tap here to enter text. |
| High Level Supervisor – H0004 | Direct & Indirect | ___ Hours/Month | Home ☐ Clinic/Center ☐ Community ☐ Telehealth ☐ Other Setting ☐ Click or tap here to enter text. |

**An example of Caregiver Mediated: ( Parent-Led ABA & SSG)**
**Direct Level Practitioner H2019 (0 Hours/Week)**
Social Skills Group H2014 (0 Hours/Week)
**Mid-Level Supervisor – H0032 (10 Hours/ Month)**
**High Level Supervisor – H0004 (2 Hours/ Month)**

**Practitioner Mediated Treatment Option**
Choose an item.

**RANGE OF HOURS for Direct Level Practitioner-H2019(GRID BELOW) reflect (Beneficial- Optimal) hours.**

**Beneficial:** Hours are based on clinical assessment and are projected to meet medical needs. Beneficial hours may necessitate decreasing the number of goals or require prioritization.

**Optimal:** Hours are based on clinical assessment and are projected to provide the most optimal client outcomes.

| Practitioner Level | Service Type | Hours | Location of Services |
|---|---|---|---|
| Direct Level Practitioner – H2019 | Direct | **Range of Hours**<br>( - ) Hours/Week | Home ☐<br>Clinic/Center ☐<br>Community ☐<br>Telehealth ☐<br>Other Setting ☐<br>Click or tap here to enter text. |
| Social Skills Group – H2014 | Direct | ___ Hours/Week | Clinic/Center ☐<br>Telehealth ☐ |
| Mid-Level Supervisor – H0032 | Direct & Indirect | ___ Hours/Month | Home ☐<br>Clinic/Center ☐<br>Community ☐<br>Telehealth ☐<br>Other Setting ☐<br>Click or tap here to enter text. |

| | | | |
|---|---|---|---|
| High Level Supervisor – H0004 | Direct & Indirect | ___ Hours/Month | Home ☐<br>Clinic/Center ☐<br>Community ☐<br>Telehealth ☐<br>Other Setting ☐<br>Click or tap here to enter text. |

**An example of selecting Caregiver & Practitioner Mediated options to allow for flexibility within the authorization period-**
**Caregiver Mediated:**
**Direct Level Practitioner H2019 (0 Hours/Week)**
Social Skills Group H2014 (0 Hours/Week)
**Mid-Level Supervisor – H0032 (10 Hours/ Month)**
**High Level Supervisor – H0004 (2 Hours/ Month)**
**Practitioner Mediated:**
**Direct Level Practitioner H2019 (15-20 Hours/Week)**
Social Skills Group H2014 (0 Hours/Week)
**Mid-Level Supervisor – H0032 (12Hours/ Month)**
**High Level Supervisor –H0004 (4 Hours/ Month)**

**Recommendation Rationale:**

- **When making recommendations for treatment hours, consider assessment findings, clinical judgment, family factors (e.g., family schedule) and BACB guidelines.**
- **Recommendation rationale should be specific to the individual client's treatment needs.**
- **If client lives OOSA (Out of Service Area) recommendations must be for options within the service area or Telehealth (e.g., Clinic or family member's home in the service area).**
- **If an educational setting is clinically recommended the following is needed:**
  - **Rationale for medical necessity**
  - **Coordination of care cited in below section with the CCS and educational personnel**
  - **Generalization criteria needs to include educational Provider/Aide**
  - **Fade plan**
  - **Education setting should rarely be the sole location of services. If this is what is being recommended, CCS consultation is required.**

Click or tap here to enter text.

**Are In-Person Services Recommended? ☐ Yes ☐ No**

**If "yes," please provide risk/benefit rationale below:**
Click or tap here to enter text.

**Was an in-person service delivery attestation completed since last report submission?**
**☐ Yes ☐ No**

**CURRENT AUTHORIZATION**

| **Current Authorization Treatment Start / End Date:** Click or tap to enter a date. - Click or tap to enter a date. | |
|---|---|
| **Service** | **Hours** |
| Direct Service Practitioner – H2019 (weekly) | **Range of Hours**<br>( - ) Hours/Week |
| Social Skills Group – H2014 (only if part of treatment plan with ABA) (weekly) | ____ Hours/Week |
| Mid-Level Supervisor– H0032 (monthly) | ___ Hours/Month |
| High-Level Supervisor– H0004 (monthly) | ___ Hours/Month |

| **Average Hours Provided for This Authorization Period** | |
|---|---|
| **Service** | **Hours** |
| Direct Service Practitioner – H2019 (weekly) | ____ Hours/Week |
| Social Skills Group – H2014 (weekly) | ____ Hours/Week |
| Mid-Level Supervisor– H0032 (monthly) | ___ Hours/Month |

| | |
|---|---|
| High-Level Supervisor– H0004 (monthly) | ___ Hours/Month |

**SERVICE DELIVERY**

**There was a Gap in direct treatment services (If yes, provide a rationale below)**
**A Gap in direct treatment is defined as services (i.e., H2019/H0032/H0004) were not provided for more than 10 business days.**
Choose an item.
Click or tap here to enter text.

**A Gap in direct treatment services occurred, client/ caregiver was offered an appointment every 10 business days. (If no, provide a rationale below)**
**Direct treatment offers could be provided at any level of service authorized (i.e., H0032/H0004/ H2019). Documentation of offers are required. For more information on documentation requirements, reference provider manual.**

**Last Date of Billed Services:** Click or tap to enter a date.

**REASON FOR** Choose an item.
Click or tap here to enter text.

| **Guidelines for Discharge from ABA Episode of Care** | |
|---|---|
| ***Discharge: Episode of Care Complete*** | ***Discharge: ABA not appropriate or no longer appropriate*** |
| ▪ Cognitive potential has been reached and no significant life interfering maladaptive behaviors are present OR<br><br>▪ The client has achieved adequate stabilization and behaviors can be managed in a less intensive treatment/environment OR<br><br>▪ The client can be treated with a less intensive level of care (e.g., community social program) OR | • Improvements are not maintained or generalized OR<br><br>• There is a lack of meaningful progress (e.g., no change in adaptive domains) OR<br><br>• Treatment is making the symptoms persistently worse (e.g., maladaptive behavior occurs more during ABA sessions; a trial of stopping ABA results in improved behavior) OR<br><br>• Client becomes too fatigued with school/Day Program and ABA OR |

| | |
|---|---|
| ▪ Behavior change is meaningful and sustainable (see definition of meaningful change) OR<br><br>▪ Behavior is within normal limits when compared to peers without ASD who have a similar intellectual level | • Family members / caregivers are unable to support ABA and **no or minimal progress** has been made as a result (e.g., excess cancelations result in no progress). ***NOTE:*** *Discharge is based on progress not parent participation. Before discharge every effort should be made to support family/parents so that ABA can continue* OR<br><br>• Client is 12 or older and has the ability to decline ABA (e.g., is able to express their desire to stop ABA) OR<br><br>• Behavior is more related to non-ASD mental health symptoms such as an anxiety disorder |

**PLAN FOR** Choose an item.
Click or tap here to enter text.

**ADMINISTRATIVE DISCHARGE**

**If Discharge is due to administrative reason(s) (e.g., insurance change, family schedule, vacation etc.), but treatment is still clinically recommended, please provide rationale for continued Behavioral Health Treatment services.**
Click or tap here to enter text.

**Did care coordination occur during this authorization period? Yes ☐ No ☐**
**If" No," Please provide reason:** Choose an item.

**Coordination of Care:**
***(Other Behavioral Health Treatment, supplementary services, CCS Care Team, or educational entities with which collaboration for treatment recommendations occurred within this reporting period). Note that if you recommend services in an educational setting, collaboration with the CCS and school personnel needs to be included in this section.***

| Type of Collaboration/Coordination & Description | Name and/or Role | Date(s) and/or frequency of Collaboration |
|---|---|---|
| Choose an item. Click or tap here to enter text. | | Click or tap to enter a date. |
| Choose an item. Click or tap here to enter text. | | Click or tap to enter a date. |

| | | |
|---|---|---|
| Choose an item. Click or tap here to enter text. | | Click or tap to enter a date. |
| Choose an item. Click or tap here to enter text. | | Click or tap to enter a date. |

**PROGRESS REPORT & TREATMENT PLAN**

- **Clients 12 years and older goals should focus on increasing quality of life and independence. Functional, curriculum-based programs are strongly recommended.**
- **Clients 6 and older without meaningful vocal language should focus on functional verbal behavior and socially significant behavioral skills.**

Below is the treatment plan for intervention and provider's report on progress toward goal mastery. Treatment plans are based on ongoing assessment, response to treatment, priorities of the individual, and input from any other professionals that support the family.

| **SLEEP CHECKLIST**<br>**Inclusion of Parent Report & Progress on Sleep Goals** | |
|---|---|
| Is sleep/bedtime a significant problem? | Choose an item.<br>If **Yes**, answer questions below |
| Goals for Sleep/Bedtime | |
| Caregiver training goals addressing sleep/bedtime | Choose an item.<br>If **No**, provide a clinical rationale:<br>Click or tap here to enter text. |
| Progress<br>**Reporting on progress relates directly to caregiver training goals.**<br>**Improved= Gains made from Baseline measure**<br>**No Change= Equivalent to Baseline measure**<br>**Worse= Regression from Baseline measure.**<br>**No Longer Present= No longer an area of concern** | |
| Difficulty falling asleep | Choose an item. |
| Frequent waking & stays awake | Choose an item. |
| Problem behaviors associated with bedtime | Choose an item. |
| Excessive daytime sleepiness (N*ot associated with a medical condition*) | Choose an item. |
| Inadequate Nighttime Sleep Duration | Choose an item. |

**RECEPTIVE COMMUNICATION**

Skills in this domain target a client's responses to communication from others across settings, communication partners, and language functions.

1. **Treatment Goal: (within six-months)** Click or tap here to enter text.
   **Goal Status:** Choose an item.
   **Assessment Tool Source:**
   **Baseline Date and Brief Description:** Click or tap to enter a date. Click or tap here to enter text.
   **Generalization Criteria:** Choose an item.
   **If choosing Not Applicable, provide a rationale as to why it is not needed.**
   **Goal Attainment Scale Score:** Choose an item.
   **Progress:**
   Click or tap here to enter text.

   **Graphic Display: Strongly Recommended**
   **(Line graph, bar graph, table, cumulative graph used to evaluate progress during treatment)**

**EXPRESSIVE COMMUNICATION**

Skills in this domain target a client's functional use of expressive language across settings, communication partners, and language functions.

2. **Treatment Goal: (within six-months)** Click or tap here to enter text.
   **Goal Status:** Choose an item.
   **Assessment Tool Source:**
   **Baseline Date and Brief Description:** Click or tap to enter a date. Click or tap here to enter text.
   **Generalization Criteria:** Choose an item.
   **If choosing Not Applicable, provide a rationale as to why it is not needed.**
   **Goal Attainment Scale Score:** Choose an item.
   **Progress:**
   Click or tap here to enter text.

   **Graphic Display: Strongly Recommended**
   **(Line graph, bar graph, table, cumulative graph used to evaluate progress during treatment)**

**PRAGMATIC COMMUNICATION**

Skills in this domain target a client's functional use of communication, imitation, and joint attention in interaction with others and in social environments

3. **Treatment Goal: (within six-months)** Click or tap here to enter text.
   **Goal Status:** Choose an item.
   **Assessment Tool Source:**
   **Baseline Date and Brief Description:** Click or tap to enter a date. Click or tap here to enter text.
   **Generalization Criteria:** Choose an item.
   **If choosing Not Applicable, provide a rationale as to why it is not needed.**
   **Goal Attainment Scale Score:** Choose an item.
   **Progress:**
   Click or tap here to enter text.

   **Graphic Display: Strongly Recommended**
   **(Line graph, bar graph, table, cumulative graph used to evaluate progress during treatment)**

**SELF HELP / DAILY LIVING SKILLS**

Skills in this domain focus on activities of daily living including developmentally appropriate personal independence (eating, dressing, hygiene, household responsibilities), safety, play and leisure (independent and with adult and peer partners), and community skills.

4. **Treatment Goal: (within six-months)** Click or tap here to enter text.
   **Goal Status:** Choose an item.
   **Assessment Tool Source:**
   **Baseline Date and Brief Description:** Click or tap to enter a date. Click or tap here to enter text.
   **Generalization Criteria:** Choose an item.
   **If choosing Not Applicable, provide a rationale as to why it is not needed.**
   **Goal Attainment Scale Score:** Choose an item.
   **Progress:**
   Click or tap here to enter text.

   **Graphic Display: Strongly Recommended**
   **(Line graph, bar graph, table, cumulative graph used to evaluate progress during treatment)**

**BEHAVIOR**

This domain focuses on behavioral excesses and skill deficits, which pose a risk to the client or others, or present a clinically significant need for intervention.

5. **Treatment Goal: (within six-months)** Click or tap here to enter text.
   **Goal Status:** Choose an item.
   **Assessment Tool Source:**
   **Baseline Date and Brief Description:** Click or tap to enter a date. Click or tap here to enter text.
   **Generalization Criteria:** Choose an item.
   **If choosing Not Applicable, provide a rationale as to why it is not needed.**
   **Goal Attainment Scale Score:** Choose an item.
   **Progress:**
   Click or tap here to enter text.

   **Graphic Display: Strongly Recommended**
   **(Line graph, bar graph, table, cumulative graph used to evaluate progress during treatment)**

**FUNCTIONAL BEHAVIOR ASSESSMENT AND BEHAVIOR PLAN (IF APPLICABLE)**

**Is physical intervention clinically indicated? ☐ Yes ☐ No**
Click or tap here to enter text.

**If physical intervention is clinically indicated, has the intervention in this treatment plan been reviewed and approved by the CCS? ☐ Yes ☐ No**
Click or tap here to enter text.

**Has the intervention been reviewed with parent/caregiver/client and are they in agreement with described intervention? ☐ Yes ☐ No**
Click or tap here to enter text.

**If Dangerous Behaviors are Present, list assessment tool source(s) used**
Choose an item.

**Behavior Support Plan (if indicated):**

Click or tap here to enter text.

**BEHAVIORAL CRISIS PLAN:**
**If applicable, this is a plan agreed upon by the treatment team, client, and caregivers in the event behavioral escalation will result in imminent harm to the client and/or**

**others or significantly threaten the safety of the client or others in the home or community.**

**This is a plan individualized to the client's identified behaviors, the environment in which the plan would need to be executed, and to the abilities of those implementing the plan.**

**If any kind of restraint is to be used as part of the plan, this should be clearly documented here along with the qualifications and training of those utilizing that intervention. Please refer and follow guidance provided in the CCS Provider Manual under *Client Restraints.***

Click or tap here to enter text.

**CAREGIVER TRAINING**

This domain is focused on education for caregivers. Goals are developed in collaboration with the caregivers and reflect their identified needs and priorities.

**Caregiver Participation**

Compliance with treatment recommendations and active parent/caregiver participation is essential to optimal client progress in programs. Treatment aims at empowering parent(s)/caregiver(s) to independently carry over strategies to their daily lives thus enabling independence and fulfillment for the client and their family.

1. **Treatment Goal: (within six-months)** Click or tap here to enter text.
   **Goal Status:** Choose an item.
   **Assessment Tool Source:**
   **Baseline Date and Brief Description:** Click or tap to enter a date. Click or tap here to enter text.
   **Generalization Criteria:** Choose an item.
   **If choosing Not Applicable, provide a rationale as to why it is not needed.**
   **Goal Attainment Scale Score:** Choose an item.
   **Progress:**
   Click or tap here to enter text.
   **Graphic Display: Strongly Recommended**
   **(Line graph, bar graph, table, cumulative graph used to evaluate progress during treatment)**

**SUMMARY**

**SUMMARY OF PROGRESS**

Click or tap here to enter text.

| | |
|---|---|
| **BARRIERS TO SERVICE** | **Environmental or family concerns that are likely to have significantly impacted service delivery in the last treatment period.**<br>☐ Yes<br>☐ No<br>**Examples could include:**<br>• **Significant changes in family (e.g., divorce, remarriage, new siblings, moving, death in the family)**<br>• **Illness, mental illness, or other disabilities in the family (other than the client)**<br>• **Socioeconomic insecurity (e.g., poverty, immigration issues, housing issues, unsafe neighborhood)**<br>• **Changes in school placement**<br>• **Home environment may be inappropriate for service delivery, or an inappropriate work environment for staff**<br><br>**If any of these factors are present and identified as having an impact on service delivery, please contact your CCS Clinical Case Manager for support.** |
| **DOES CLIENT EXHIBIT DANGEROUS BEHAVIORS (inclusive of any dangerous behaviors observed during or outside of treatment)?**<br>**☐ Yes ☐ No**<br>**INCLUSION OF CAREGIVER REPORT & GOAL PROGRESS**<br><br>**Dangerous behaviors are a subset of maladaptive or problem behaviors; severe behaviors that could result in physical** | **If "Yes," please select all that apply:**<br>☐ **Self-injurious behavior** that could result in the need for first aid or medical attention<br>• Age or date of onset (estimated) Choose an item. Click or tap to enter a date.<br>• Frequency: Choose an item.<br>• Intensity: Choose an item.<br>☐ **Physical harm to others** that could result in the need for first aid or medical attention<br>• Age or date of onset (estimated) Choose an item. Click or tap to enter a date.<br>• Frequency: Choose an item.<br>• Intensity: Choose an item. |

| | |
|---|---|
| **injury requiring first aid or medical attention or behaviors that could result in law enforcement involvement.**<br><br>**Behavior Support Plan (BSP) to be implemented (see BSP above)?**<br><br>**☐ Yes ☐ No**<br>**If "No," Rationale:**<br><br>Click or tap here to enter text. | ☐ **Dangerous elopement** that is not age-appropriate and could result in injury<br>• Age or date of onset (estimated) Choose an item. Click or tap to enter a date.<br>• Frequency: Choose an item.<br>• Intensity: Choose an item.<br>☐ **Sexually inappropriate behavior** that could result in physical harm, serious complaint from others or law enforcement involvement<br>• Age or date of onset (estimated) Choose an item. Click or tap to enter a date.<br>• Frequency: Choose an item.<br>• Intensity: Choose an item.<br>☐ **Property destruction** that could result in law enforcement involvement<br>• Age or date of onset (estimated) Choose an item. Click or tap to enter a date.<br>• Frequency: Choose an item.<br>• Intensity: Choose an item.<br>☐ **Eating food or non-food items** that is not age-appropriate and could result in medical attention<br>• Age or date of onset (estimated) Choose an item. Click or tap to enter a date.<br>• Frequency: Choose an item.<br>• Intensity: Choose an item.<br>☐ **Behaviors connected to elimination** that could result in physical harm or are severely socially inappropriate<br>• Age or date of onset (estimated) Choose an item. Click or tap to enter a date.<br>• Frequency: Choose an item.<br>• Intensity: Choose an item.<br>☐ **Other** behaviors that might lead to physical harm or lead to law enforcement involvement<br>< insert description ><br>• Age or date of onset (estimated) Choose an item. Click or tap to enter a date.<br>• Frequency: Choose an item. |

| | |
|---|---|
| | • Intensity: Choose an item. |

**EMERGENCY / CRISIS PLAN**

In the event of an unexpected crisis during sessions, treatment staff will follow the general guidelines outlined below:

- Responsible adult oversees client safety
- Treatment staff will ensure safety of self
- If the Responsible adult is unavailable or unable to help, treatment staff will assist by calling 911 if appropriate and possible
- Treatment staff will inform supervisor of the incident as soon as possible
- Immediate notification to the CCS and submission of a Reportable Event Form within 1 business day of the incident

**GOAL ATTAINMENT SCALE OVERALL PROGRESS**

| *** Includes acquisition, behavior reduction & caregiver training goals.**<br><br>**Do not include goals that are new, on hold or discontinued.** | **Total Number of Goals for Client & Caregiver** |
|---|---|
| Goals at 0 (Not Met - No Progress within Reporting Period) | |
| Goals at 1 (Not Met - Some Progress within Reporting Period) | |
| Goals at 2 (Goal Met - Expected outcome) | |
| Goals at 3 (Goal Met - Somewhat more than expected outcome) | |
| Goals at 4 (Goal Met - Much more than expected outcome) | |
| Total Goals Met Score (add goals scored 2, 3, & 4 on GAS) | |
| Total Percentage of Goals Met (total goals met divided by ALL goals listed above) | |

**TOTAL GOALS FOR CLIENT & CAREGIVER**

| | |
|---|---|
| **Total Goals: met, continued, revised, on hold or discontinued** | |
| **Count of New Goals Added for Next Reporting Period** | |

| **Treatment Plan Review Date with Family:**<br>(Provider met with client/family to provide update and obtain their input on treatment)<br>*NOTE: Ensure client/family is provided a copy of this report following its authorization.* | |
|---|---|
| **Report Reviewed with Client/Family?** | Yes ☐ Click or tap to enter a date. |
| | No ☐ Reason: Click or tap here to enter text. |

CATALIGHT
CARE SERVICES

Client Name:Click or tap here to enter text.
Client MRN:Click or tap here to enter text.
Date of Report: Click or tap here to enter text.

**Please contact us or your CCS Clinical Case Manager at 855-843-2476 directly with any additional questions or comments related to this report.**

Respectfully Submitted,

| | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap to enter a date. |
|---|---|---|---|
| Signature | Print Name and Title | License/Cert.# | Date<br>This date should match the date in the header. |
| | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap to enter a date. |
| Signature | Print Name and Title | License/Cert.# | Date |

# Addendum Report

## Select Service Line

| | |
|---|---|
| **Provider Name OR** | Click or tap here to enter text. |

CATALIGHT
CARE SERVICES

Client Name: Click or tap here to enter text.
Client MRN: Click or tap here to enter text.
Date of Report: Click or tap here to enter text.

| **Provider Logo (optional)** | |
|---|---|

**CLIENT INFORMATION**

| | |
|---|---|
| **Provider Name:** | Click or tap here to enter text. |
| **Client Full Legal Name:** | Click or tap here to enter text. |
| **Date of Birth:** | Click or tap to enter a date. |

**SELECT REASON FOR ADDENDUM**

☐ New Treatment Goals (include all new or revised goals below)
☐ Request for Change in Treatment Hours
☐ Request for Change in Service Line
☐ Request for Change in Treatment Location
☐ Other: (explain below)
Click or tap here to enter text.

**RECOMMENDATIONS**

Based on assessment, observation, and the learner profile, it has been determined that intensive services as indicted below are being recommended. Direct services will be focused on skill acquisition and behavior reduction as detailed in the report below. Additionally, natural settings will be incorporated regularly into the intervention services provided as this is critical to generalizing skills for use in real world settings.

***Authorization Request (Hours agreed to by client/family)***

**Client may be clinically recommended for Caregiver Mediated and Practitioner Mediated treatment during this authorization period; however, they do not occur at the same time. Allowing flexibility to provide care throughout the authorization period to meet the beneficial treatment recommendations as defined by the assessor.**

*** Services could occur in one or all settings that are marked below****
**Any one of the marked off service locations could be clinically appropriate or could occur in one or all these settings.**
**Caregiver Mediated Treatment Option**
Choose an item.

| | | | |
|---|---|---|---|
| Direct Level Practitioner – H2019 | Direct | **0 Hours/Week** | N/A |
| ***If Applicable:*** Social Skills Group – H2014 | Direct | ___ Hours/Week | Clinic/Center ☐ Telehealth ☐ |
| Mid-Level Supervisor – H0032 | Direct & Indirect | ___ Hours/Month | Home ☐ Clinic/Center ☐ Community ☐ Telehealth ☐ Other Setting ☐ Click or tap here to enter text. |
| High Level Supervisor – H0004 | Direct & Indirect | ___ Hours/Month | Home ☐ Clinic/Center ☐ Community ☐ Telehealth ☐ Other Setting ☐ Click or tap here to enter text. |

**An example of Caregiver Mediated: (Parent-Led ABA & SSG)**
**Direct Level Practitioner H2019 (0 Hours/Week)**
**Social Skills Group H2014 (2 Hours/Week)**
**Mid-Level Supervisor – H0032 (10 Hours/ Month)**
**High Level Supervisor – H0004 (3 Hours/ Month)**

**Practitioner Mediated Treatment Option**
Choose an item.

**RANGE OF HOURS for Direct Level Practitioner-H2019(GRID BELOW)**
**reflect (Beneficial- Optimal) hours.**

**Beneficial:** Hours are based on clinical assessment and are projected to meet medical needs but may not produce the most optimal benefits. Beneficial hours may necessitate decreasing the number of goals or require prioritization
**Optimal:** Hours are based on clinical assessment and are projected to provide the most optimal client outcomes.

| Practitioner Level | Service Type | Hours | Location of Services |
|---|---|---|---|
| Direct Level Practitioner – H2019 | Direct | **Range of Hours**<br>(  ) Hours/Week | Home ☐<br>Clinic/Center ☐<br>Community ☐<br>Telehealth ☐<br>Other Setting ☐<br>Click or tap here to enter text. |
| Social Skills Group – H2014 | Direct | ___ Hours/Week | Clinic/Center ☐<br>Telehealth ☐ |
| Mid-Level Supervisor – H0032 | Direct & Indirect | ___ Hours/Month | Home ☐<br>Clinic/Center ☐<br>Community ☐<br>Telehealth ☐<br>Other Setting ☐<br>Click or tap here to enter text. |
| High Level Supervisor – H0004 | Direct & Indirect | ___ Hours/Month | Home ☐<br>Clinic/Center ☐<br>Community ☐<br>Telehealth ☐<br>Other Setting ☐<br>Click or tap here to enter text. |

**An example of selecting Caregiver & Practitioner Mediated options to allow for flexibility within the authorization period-**
**Caregiver Mediated:**
**Direct Level Practitioner H2019 (0 Hours/Week)**
Social Skills Group H2014 (0 Hours/Week)
**Mid-Level Supervisor – H0032 (10 Hours/ Month)**
**High Level Supervisor – H0004 (2 Hours/ Month)**
**Practitioner Mediated:**
**Direct Level Practitioner H2019 (15-20 Hours/Week)**
Social Skills Group H2014 (0 Hours/Week)
**Mid-Level Supervisor – H0032 (12Hours/ Month)**
**High Level Supervisor –H0004 (4 Hours/ Month)**
**Recommendation Rationale:**

- **When making recommendations for treatment hours, consider assessment findings, clinical judgment, family factors (e.g., family schedule) and BACB guidelines.**
- **Recommendation rationale should be specific to the individual client's treatment needs.**
- **If client lives OOSA (Out of Service Area) recommendations must be for options within the service area or Telehealth (e.g., Clinic or family member's home in the service area).**
- **If an educational setting is clinically recommended the following is needed:**
  - **Rationale for medical necessity**
  - **Coordination of care is needed with the CCS and educational personnel and cited in next progress report**
  - **Generalization criteria needs to include educational Provider/Aide**
  - **Fade plan**
  - **Education setting should rarely be the sole location of services. If this is what is being recommended, CCS consultation is required.**

Click or tap here to enter text.
**Are In-Person Services Recommended? ☐ Yes ☐ No**

**If "yes," please provide risk/benefit rationale below:**
Click or tap here to enter text.

**Was an in-person service delivery attestation completed since last report submission?**
**☐ Yes ☐ No**

**If clinic/center-based services are recommended, please provide pick-up/drop-off policy:**
Click or tap here to enter text.

**TREATMENT PLAN UPDATE (include all new and revised goals below)**

- **Clients 12 years and older goals should focus on increasing quality of life and independence. Functional, curriculum-based programs are strongly recommended.**
- **Clients 6 and older without meaningful vocal language should focus on functional verbal behavior and socially significant behavioral skills.**
- **Assessment and treatment planning tools vetted by the CCS can be found in the Appendix of the CCS Provider Manual.**

**RECEPTIVE COMMUNICATION**

Skills in this domain target a client's responses to communication from others across settings, communication partners, and language functions.

1. **Treatment Goal: (within six-months)** Click or tap here to enter text.
   **Goal Status:** Choose an item.
   **Assessment Tool Source:**
   **Baseline Date and Brief Description:** Click or tap to enter a date. Click or tap here to enter text.
   **Generalization Criteria:** Choose an item.
   **If choosing Not Applicable, provide a rationale as to why it is not needed.**
   **Goal Attainment Scale Score:** Choose an item.
   **Progress:**
   Click or tap here to enter text.

   **Graphic Display: Strongly Recommended**
   **(Line graph, bar graph, table, cumulative graph used to evaluate progress during treatment)**

**EXPRESSIVE COMMUNICATION**

Skills in this domain target a client's functional use of expressive language across settings, communication partners, and language functions.

2. **Treatment Goal: (within six-months)** Click or tap here to enter text.
   **Goal Status:** Choose an item.
   **Assessment Tool Source:**
   **Baseline Date and Brief Description:** Click or tap to enter a date. Click or tap here to enter text.
   **Generalization Criteria:** Choose an item.
   **If choosing Not Applicable, provide a rationale as to why it is not needed.**

**Goal Attainment Scale Score:** Choose an item.
**Progress:**
Click or tap here to enter text.

**Graphic Display: Strongly Recommended**
**(Line graph, bar graph, table, cumulative graph used to evaluate progress during treatment)**

**PRAGMATIC COMMUNICATION**

Skills in this domain target a client's functional use of communication, imitation, and joint attention in interaction with others and in social environments

3. **Treatment Goal: (within six-months)** Click or tap here to enter text.
   **Goal Status:** Choose an item.
   **Assessment Tool Source:**
   **Baseline Date and Brief Description:** Click or tap to enter a date. Click or tap here to enter text.
   **Generalization Criteria:** Choose an item.
   **If choosing Not Applicable, provide a rationale as to why it is not needed.**
   **Goal Attainment Scale Score:** Choose an item.
   **Progress:**
   Click or tap here to enter text.

   **Graphic Display: Strongly Recommended**
   **(Line graph, bar graph, table, cumulative graph used to evaluate progress during treatment)**

**SELF HELP / DAILY LIVING SKILLS**

Skills in this domain focus on activities of daily living including developmentally appropriate personal independence (eating, dressing, hygiene, household responsibilities), safety, play and leisure (independent and with adult and peer partners), and community skills.

4. **Treatment Goal: (within six-months)** Click or tap here to enter text.
   **Goal Status:** Choose an item.
   **Assessment Tool Source:**
   **Baseline Date and Brief Description:** Click or tap to enter a date. Click or tap here to enter text.
   **Generalization Criteria:** Choose an item.

**If choosing Not Applicable, provide a rationale as to why it is not needed.**
**Goal Attainment Scale Score:** Choose an item.
**Progress:**
Click or tap here to enter text.
**Graphic Display: Strongly Recommended**
**(Line graph, bar graph, table, cumulative graph used to evaluate progress during treatment)**

**BEHAVIOR**

This domain focuses on behavioral excesses and skill deficits, which pose a risk to the client or others, or present a clinically significant need for intervention.

5. **Treatment Goal: (within six-months)** Click or tap here to enter text.
   **Goal Status:** Choose an item.
   **Assessment Tool Source:**
   **Baseline Date and Brief Description:** Click or tap to enter a date. Click or tap here to enter text.
   **Generalization Criteria:** Choose an item.
   **If choosing Not Applicable, provide a rationale as to why it is not needed.**
   **Goal Attainment Scale Score:** Choose an item.
   **Progress:**
   Click or tap here to enter text.
   **Graphic Display: Strongly Recommended**
   **(Line graph, bar graph, table, cumulative graph used to evaluate progress during treatment)**

**FUNCTIONAL BEHAVIOR ASSESSMENT AND BEHAVIOR PLAN (IF APPLICABLE)**
**Is physical intervention clinically indicated? ☐ Yes ☐ No**

Click or tap here to enter text.

**If physical intervention is clinically indicated, has the intervention in this treatment plan been reviewed and approved by the CCS? ☐ Yes ☐ No**

Click or tap here to enter text.

**Has the intervention been reviewed with parent/caregiver/client and are they in agreement with described intervention? ☐ Yes ☐ No**

Click or tap here to enter text.

**If Dangerous Behaviors are Present, list assessment tool source(s) used**

Choose an item.

**Behavior Support Plan (if indicated):**
Click or tap here to enter text.

**BEHAVIORAL CRISIS PLAN:**
**If applicable, this is a plan agreed upon by the treatment team, client, and caregivers in the event behavioral escalation will result in imminent harm to the client and/or others or significantly threaten the safety of the client or others in the home or community.**

**This is a plan individualized to the client's identified behaviors, the environment in which the plan would need to be executed, and to the abilities of those implementing the plan.**

**If any kind of restraint is to be used as part of the plan, this should be clearly documented here along with the qualifications and training of those utilizing that intervention. Please refer and follow guidance provided in the CCS Provider Manual under *Client Restraints.***

Click or tap here to enter text.

## CAREGIVER TRAINING

This domain is focused on education for caregivers. Goals are developed in collaboration with the caregivers and reflect their identified needs and priorities.

**Caregiver Participation**
Compliance with treatment recommendations and active parent/caregiver participation is essential to optimal client progress in programs. Treatment aims at empowering parent(s)/caregiver(s) to independently carry over strategies to their daily lives thus enabling independence and fulfillment for the client and their family.

1. **Treatment Goal: (within six-months)** Click or tap here to enter text.
   **Goal Status:** Choose an item.
   **Assessment Tool Source:**

**Baseline Date and Brief Description:** Click or tap to enter a date. Click or tap here to enter text.
**Generalization Criteria:** Choose an item.
**If choosing Not Applicable, provide a rationale as to why it is not needed.**
**Goal Attainment Scale Score:** Choose an item.
**Progress:**
Click or tap here to enter text.

**Graphic Display: Strongly Recommended**
**(Line graph, bar graph, table, cumulative graph used to evaluate progress during treatment)**

**SUMMARY**
**SUMMARY OF PROGRESS**
Click or tap here to enter text.

| | |
|---|---|
| **BARRIERS TO SERVICE** | **Environmental or family concerns that are likely to have significantly impacted service delivery in the last treatment period.**<br><br>☐ Yes<br><br>☐ No<br><br>**Examples could include:**<br>• **Significant changes in family (e.g., divorce, remarriage, new siblings, moving, death in the family)**<br>• **Illness, mental illness, or other disabilities in the family (other than the client)**<br>• **Socioeconomic insecurity (e.g., poverty, immigration issues, housing issues, unsafe neighborhood)**<br>• **Changes in school placement**<br>• **Home environment may be inappropriate for service delivery, or an inappropriate work environment for staff**<br><br>**If any of these factors are present and identified as having an impact on service delivery, please contact your CCS Clinical Case Manager for support.** |

| | |
|---|---|
| **DOES CLIENT EXHIBIT DANGEROUS BEHAVIORS? (Inclusive of any dangerous behaviors observed during or outside of treatment)?**<br><br>☐ **Yes** ☐ **No**<br><br>**INCLUSION OF CAREGIVER REPORT & GOAL PROGRESS**<br><br>**Dangerous behaviors are a subset of maladaptive or problem behaviors; severe behaviors that could result in physical injury requiring first aid or medical attention or behaviors that could result in law enforcement involvement.**<br><br>**Behavior Support Plan (BSP) to be implemented (see BSP above)?**<br><br>☐ **Yes** ☐ **No**<br><br>**If "No," Rationale:**<br><br>Click or tap here to enter text. | **If "Yes," please select all that apply:**<br><br>☐ **Self-injurious behavior** that could result in the need for first aid or medical attention<br>• Age or date of onset (estimated) Choose an item. Click or tap to enter a date.<br>• Frequency: Choose an item.<br>• Intensity: Choose an item.<br>☐ **Physical harm to others** that could result in the need for first aid or medical attention<br>• Age or date of onset (estimated) Choose an item. Click or tap to enter a date.<br>• Frequency: Choose an item.<br>• Intensity: Choose an item.<br>☐ **Dangerous elopement** that is not age-appropriate and could result in injury<br>• Age or date of onset (estimated) Choose an item. Click or tap to enter a date.<br>• Frequency: Choose an item.<br>• Intensity: Choose an item.<br>☐ **Sexually inappropriate behavior** that could result in physical harm, serious complaint from others or law enforcement involvement<br>• Age or date of onset (estimated) Choose an item. Click or tap to enter a date.<br>• Frequency: Choose an item.<br>• Intensity: Choose an item.<br>☐ **Property destruction** that could result in law enforcement involvement<br>• Age or date of onset (estimated) Choose an item. Click or tap to enter a date.<br>• Frequency: Choose an item.<br>• Intensity: Choose an item.<br>☐ **Eating food or non-food items** that is not age-appropriate and could result in medical attention<br>• Age or date of onset (estimated) Choose an item. Click or tap to enter a date.<br>• Frequency: Choose an item. |

| | |
|---|---|
| | • Intensity: Choose an item.<br>☐ **Behaviors connected to elimination** that could result in physical harm or are severely socially inappropriate<br>• Age or date of onset (estimated) Choose an item. Click or tap to enter a date.<br>• Frequency: Choose an item.<br>• Intensity: Choose an item.<br>☐ **Other** behaviors that might lead to physical harm or lead to law enforcement involvement<br>< insert description ><br>• Age or date of onset (estimated) Choose an item. Click or tap to enter a date.<br>• Frequency: Choose an item.<br>• Intensity: Choose an item. |

**ANTICIPATED DISCHARGE DATE:** Click or tap to enter a date.

**FADE PLAN *(required if anticipated discharge date is within 6 months):***

Click or tap here to enter text. **Provide a client specific fade plan which could include:**

- **Breakdown of how hours and/or the service line/s will adjust over the next 6 months**
- **Increased caregiver participation as services fade.**
- **Clear and measurable objectives**

**ANTICIPATED DISCHARGE DATE CHANGED SINCE LAST REPORT? Yes ☐ NO ☐**

**REASON FOR CHANGE:** Click or tap here to enter text.

**Please contact us or your CCS Clinical Case Manager at 855-843-2476 directly with any additional questions or comments related to this report.**

Respectfully Submitted,

| | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap to enter a date. |
|---|---|---|---|
| Signature | Print Name and Title | License/Cert.# | Date<br>This date should match the date in the header. |

| | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap to enter a date. |
|---|---|---|---|
| Signature | Print Name and Title | License/Cert.# | Date |

# Progress Report

## 3-Tier ABA w/ Caregiver Training
## In-Person and Telehealth

| | |
|---|---|
| **Provider Name** | ABBY's ABC |
| **Provider Logo (optional)** |  |

**CLIENT INFORMATION**

| | |
|---|---|
| **Client Full Legal Name:** | Tyler Sesame |
| **Client Preferred Name (if applicable)** | NA |
| **Date of Birth:** | 8/31/2013 |
| **Client Age in Years, Months:** *(e.g., 02 years, 08 months)* | 8 years 2 months |

| | |
|---|---|
| **Client's Race / Ethnicity** | Caucasian |
| **Client's Gender**<br>**Client's Pronouns** | Male<br>He/His |
| **Parent/Legal Guardian Name:** | Maria & Jack Sesame |
| **Parent/ Legal Guardian Address:** | 123 Apple Lane, Alameda, CA 94501 |
| **Client Resides With:**<br><br>**Client Address if Different Than Parent/Legal Guardian:** | Maria Sesame (Mother) & Jack Sesame (Father)<br><br>Click or tap here to enter text. |
| **Out of (Funder) Service Area (OOSA) Yes or No:**<br>*(If Yes, provide treatment location)* | Click or tap here to enter text. |
| **Phone Number:** | 555- 888-8888 |
| **Treatment Team:**<br>*Include contact email and phone for supervisor)* | Jack Johnson, MA, BCBA (310) 867-5309, j.johnson@abbyabc.org/ Eric Estrada, MA BCaBA/ Fraser Adams, RBT |
| **Diagnosis** (listed on authorization)**:** | Autism Spectrum Disorder |
| **Diagnosing MD or Psychologist Name AND Date of Diagnosis(es)**<br>*(If not ASD Client, use the referring physician)* | Dr. Amy Anderson, Psy.D, MD on 8/10/2015 |
| **Initial BHT Start Date:** | 8/31/2020 |
| **Academic Performance** *(School)* | IEP? Yes ☒ No ☐ |
| | Special Education / SDC? Yes ☒ No ☐ |
| | General Education? Yes ☒ No ☐ |
| | Performance in General Education (if "yes" above): Low ☐ Moderate ☒ High ☐ |
| | Educational Setting:<br>Public |

**Documented Reason for Referral:**
Referred to the CCS by Kaiser Permanente for Behavioral Health Treatment (BHT) to address communication & social delays.

**RECOMMENDATIONS**

Based on assessment, observation, and the learner profile, it has been determined that intensive services as indicted below are being recommended. Direct services will be focused on skill acquisition and behavior reduction as detailed in the report below. Additionally, natural settings will be incorporated regularly into the intervention services provided as this is critical to generalizing skills for use in real world settings.

***Authorization Request (Hours agreed to by client/family)***

**Client may be clinically recommended for Caregiver Mediated and Practitioner Mediated treatment during this authorization period; however, they do not occur at the same time.**

** *Services could occur in one or all settings that are marked below*****

**Caregiver Mediated Treatment Option**

**Caregiver Training**

| | | | |
|---|---|---|---|
| Direct Level Practitioner – H2019 | Direct | **0 Hours/Week** | N/A |
| ***If Applicable:*** Social Skills Group – H2014 | Direct | 0 Hours/Week | Clinic/Center ☐ Telehealth ☐ |
| Mid-Level Supervisor – H0032 | Direct & Indirect | **10** Hours/Month | Home ☒ Clinic/Center ☐ Community ☐ Telehealth ☒ Other Setting ☐ Click or tap here to enter text. |

| | | | |
|---|---|---|---|
| High Level Supervisor – H0004 | Direct & Indirect | **2** Hours/Month | Home ☒<br>Clinic/Center ☐<br>Community ☐<br>Telehealth ☒<br>Other Setting ☐<br>Click or tap here to enter text. |

**Practitioner Mediated Treatment Option**
**3-Tier ABA w/ Caregiver Training**

| Practitioner Level | Service Type | Hours | Location of Services |
|---|---|---|---|
| Direct Level Practitioner – H2019 | Direct | **Range of Hours (15 - 20)** Hours/Week | Home ☒<br>Clinic/Center ☐<br>Community ☐<br>Telehealth ☒<br>Other Setting ☐<br>Click or tap here to enter text. |
| Social Skills Group – H2014 | Direct | 0 Hours/Week | Clinic/Center ☐<br>Telehealth ☐ |
| Mid-Level Supervisor – H0032 | Direct & Indirect | **12** Hours/Month | Home ☒<br>Clinic/Center ☐<br>Community ☐<br>Telehealth ☒<br>Other Setting ☐<br>Click or tap here to enter text. |

| | | | |
|---|---|---|---|
| High Level Supervisor – H0004 | Direct & Indirect | **4** Hours/Month | Home ☒<br>Clinic/Center ☐<br>Community ☐<br>Telehealth ☒<br>Other Setting ☐<br>Click or tap here to enter text. |

**Recommendation Rationale:**
ABC DE FGHIJ K LM NOP QRS T UVWX YZ. ABC DE FGHIJ K LM NOP QRS T UVWX

**Are In-Person Services Recommended? ☒ Yes ☐ No**
**If "yes," please provide risk/benefit rationale below:**
ABC DE FGHIJ K LM NOP QRS T UVWX YZ. ABC DE FGHIJ K LM NOP QRS T UVWX YZ.
**Was an in-person service delivery attestation completed since last report submission?**
**☒ Yes ☐ No**
**If clinic/center-based services are recommended, please provide pick-up/drop-off policy:**
N/A

**CURRENT AUTHORIZATION**

| **Current Authorization Treatment Start / End Date:** 1/1/2021 - 7/1/2022 | |
|---|---|
| **Service** | **Hours** |
| Direct Service Practitioner – H2019 (weekly) | **Range of Hours**<br>**(15 - 20)** Hours/Week |
| Social Skills Group – H2014 (only if part of treatment plan with ABA) (weekly) | **0** Hours/Week |
| Mid-Level Supervisor– H0032 (monthly) | **12** Hours/Month |
| High-Level Supervisor– H0004 (monthly) | **4** Hours/Month |

| Average Hours Provided for This Authorization Period | |
|---|---|
| **Service** | **Hours** |
| Direct Service Practitioner – H2019 (weekly) | **16** Hours/Week |
| Social Skills Group – H2014 (weekly) | 0 Hours/Week |
| Mid-Level Supervisor– H0032 (monthly) | **11** Hours/Month |
| High-Level Supervisor– H0004 (monthly) | **3.5** Hours/Month |

**SERVICE DELIVERY**

**There was a Gap in direct treatment services (If yes, provide a rationale below)**
**YES**

The RBT assigned to Tyler's case, Fraser Adams had to take a leave of absence between February 1, 2022- March 5, 2022. The family declined sub sessions during this time; however, they accepted caregiver training sessions on Mondays (6:00-7:00pm) via telehealth & Fridays (9:00-11:00am) in the home. During this time there was 1 cancellation due to family illness on 2/11/22. Once the assigned RBT, Fraser Adams returned on March 6, 2022 the Practitioner Mediated treatment was reinstated.

**A Gap in direct treatment services occurred, client/ caregiver was offered an appointment every 10 business days. (If no, provide a rationale below)**
**YES**

N/A

**Social Skills Group description, if applicable:**

Choose an item.
N/A

**EDUCATIONAL SERVICES:**

Total number of hours of education services comprised of the following:

| Service | Service Dates | Intensity (Hours Per Week/Month) |
|---|---|---|
| Apple Valley Elementary | August 2019- Present | Monday- Friday 8:30am-3:00pm |

**OTHER SERVICES**

Total number of hours of other services comprised of the following (including extracurricular activities):

| Service | Service Dates | Intensity (Hours Per Week/Month) |
|---|---|---|
| Boy Scouts | January 9, 2020- Present | Saturdays 10-1pm |

**Did care coordination occur during this authorization period? Yes ☒ No ☐**
**If" No,", Please provide reason:** Choose an item.
**Coordination of Care:**
***(Other Behavioral Health Treatment, supplementary services, CCS care teams, or educational entities with which collaboration for treatment recommendations occurred):***

| Type of Collaboration/Coordination & Description | Name and/or Role | Date(s) and/or frequency of Collaboration |
|---|---|---|
| Educational Provider/School Click or tap here to enter text. | Mrs. Smith, 3rd Grade Gen Ed Teacher | 5/13/2022 |
| CCS Care Team Collaboration Click or tap here to enter text. | Jack Edwards, CCS BCBA Consultant | 5/10/2022 |
| Phone Consultation Click or tap here to enter text. | Dr. Yoon, MD, Pediatrician | 5/19/2022 |

**ADAPTIVE BEHAVIOR ASSESSMENT**
***If Vineland-3 Update Not Completed, please provide rationale and timeline for completion:***
**N/A**

Vineland Adaptive Scales, 3rd edition was used to assess the individual's adaptive behavior functioning. The standard scores reported have an average of 100 and a standard deviation of 15. Age-equivalents indicate the average age of the individual from the Vineland-3 normative sample who obtained the same raw score as the individual currently being assessed. Adaptive levels are scored on a 5-point scale from Low to High.

Individuals over the age of three will include Maladaptive Behavior Index (MBI).

| | |
|---|---|
| **Vineland-3 Form Used** (Comprehensive Interview Form / Comprehensive Parent Caregiver Form) | |
| **Vineland-3 Assessment Date** | 6/2/2022 |
| **Name of Respondent** | Maria |
| **Relationship of Respondent to Client** | Mother |

***The table below is copied from Q-Global Report:***

| Domain | Standard Score | V-Scale Score | Adaptive Level | Percentile Rank | Age Equivalent |
|---|---|---|---|---|---|
| **Communication** | 43 | | Low | <1 | |
| Receptive | | 8 | Low | | 1 year, 11 months |
| Expressive | | 2 | Low | | 1 year, 4 months |
| **Daily Living Skills** | 56 | | Low | <1 | |
| Personal | | 5 | Low | | |
| Domestic | | 8 | Low | | |
| Community | | 7 | Low | | |
| **Socialization** | 68 | | | 2 | |
| Interpersonal Relationships | | 10 | Moderately Low | | 1 year, 9 months |

| | | | | | |
|---|---|---|---|---|---|
| Play and Leisure Time | | *8* | Low | | *< 3 years* |
| Coping Skills | | *9* | Low | | *< 3 years* |
| **Maladaptive Behavior (optional)** | | | | | |
| Internalizing | | *18* | *Elevated* | | |
| Externalizing | | *18* | *Elevated* | | |
| Other | | | | | |
| **Adaptive Behavior Composite** | *59* | | | | |

**ASSESSMENT RESULTS**

ABC DE FGHIJ K LM NOP QRS T UVWX YZ. ABC DE FGHIJ K LM NOP QRS T UVWX YZ.

| **SLEEP CHECKLIST**<br>**Inclusion of Caregiver Report & Progress on Sleep Goals** | |
|---|---|
| Is sleep/bedtime a significant problem? | **YES**<br>If **Yes**, answer questions below |
| Goals for Sleep/Bedtime | |
| Caregiver training goals addressing sleep/bedtime | **YES**<br>If **No**, provide a clinical rationale:<br>Click or tap here to enter text. |
| Progress | |
| Difficulty falling asleep | Improved |
| Frequent waking & stays awake | Choose an item. |
| Problem behaviors associated with bedtime | Improved |
| Excessive daytime sleepiness (N*ot associated with a medical condition*) | Choose an item. |
| Inadequate Nighttime Sleep Duration | Choose an item. |

**Client Strengths:**

- **Tyler is motivated to initiate play with peers.**
- **Tyler asks for help when he is unable to complete a task independently.**
- **Tyler will establish and maintain eye contact when asking for things he wants/needs.**
- **Tyler will respond to verbal and nonverbal gestures.**

**Desired Outcomes of Behavioral Health Treatment for Client / Family:**

- **Tyler will use coping strategies when he is upset.**
- **Tyler will increase communication skills**
- **Tyler will be able to maintain friendships with kids who have likeminded interests**
- **Tyler will understand and follow through with instructions.**
- **Tyler will follow a sleep routine**

**PROGRESS REPORT & TREATMENT PLAN**

Below is the treatment plan for intervention and provider's report on progress toward goal mastery. Treatment plans are based on ongoing assessment, response to treatment, priorities of the individual, and input from other professionals that support the family.

**RECEPTIVE COMMUNICATION**

Skills in this domain target a client's responses to communication from others across settings, communication partners, and language functions.

1. **Treatment Goal: (within six-months)** Tyler will respond to at least 3, 1 step instructions in an average of 80% of opportunities across a three-month period.

**Goal Status:** Met

**Assessment Tool Source:** EFL LR 13-15

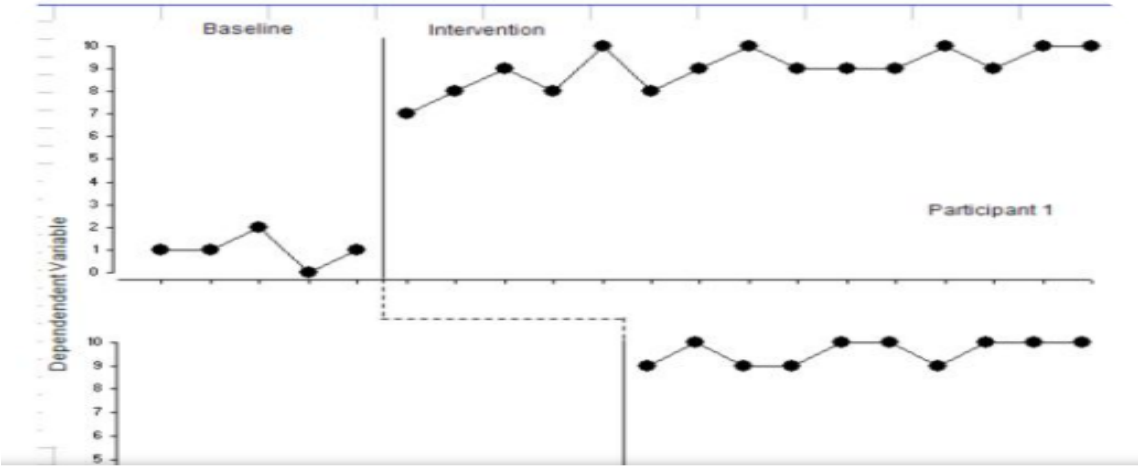
**Baseline Date and Brief Description: 1/1/2022** Tyler responds to 0, 1 step instructions out of 5 opportunities

**Generalization Criteria: Generalization Across Contexts / Environments**

**Goal Attainment Scale Score:** 4 - Much more than expected outcome - Goal met

**Progress:** Tyler will respond to 5, 1 step instructions with 80% accuracy across a three-month period.

**Graphic Display:**




**EXPRESSIVE COMMUNICATION**

Skills in this domain target a client's functional use of expressive language across settings, communication partners, and language functions.

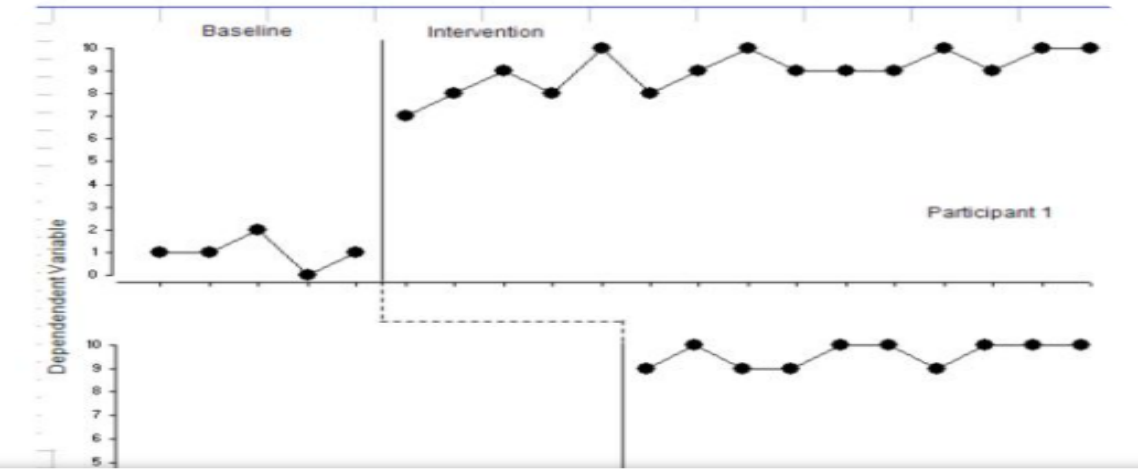
2. **Treatment Goal: (within six-months)** Tyler will request for the termination (to end) of a non-preferred activity (e.g., turn off tv, wash hands, leave house, etc.) in the absence of a problem behavior/s (e.g., spitting, hitting, kicking,) across at least 5 different scenarios in an average of 60% of opportunities across a three-month period.
   **Goal Status:** New Goal
   **Assessment Tool Source:** EFL R41
   **Baseline Date and Brief Description: 6/1/2022** Tyler will request using "No thanks." to end a non preferred activity in 1/ 5 opportunities.
   **Generalization Criteria: Generalization to Parents/Caregivers**

   **Goal Attainment Scale Score:** New Goal
   **Progress:** NA
   **Graphic Display:**

**PRAGMATIC COMMUNICATION**

Skills in this domain target a client's functional use of communication, imitation, and joint attention in interaction with others and in social environments

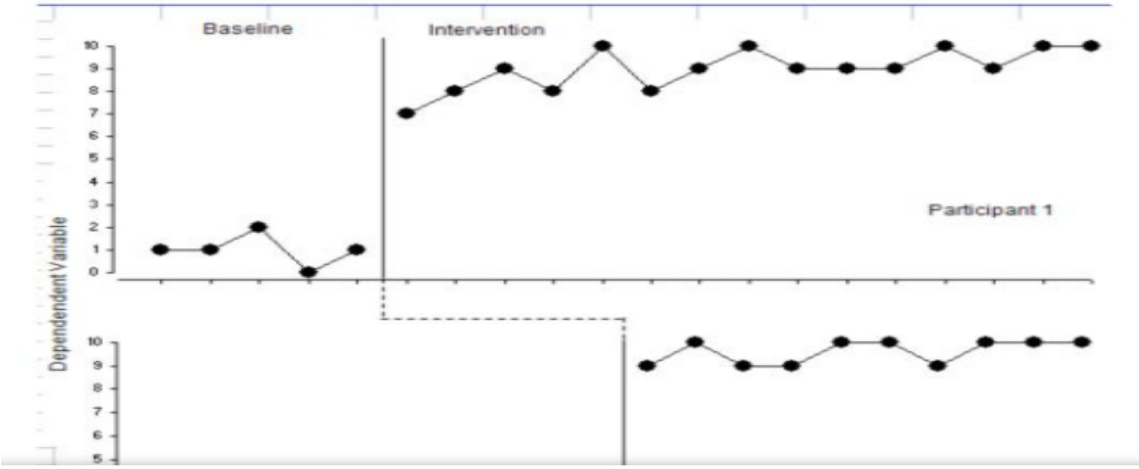
3. **Treatment Goal: (within six-months)** Tyler will tolerate a peer sitting/ standing within a 6-foot distance during a play activity for a duration of at least 10 minutes across at least 3 consecutive weeks.
   **Goal Status:** Continued
   **Assessment Tool Source:** EFL T-BH15a
   **Baseline Date and Brief Description: 1/1/2022** Tyler will tolerate a peer sitting/ standing within a 6-foot distance during a play activity for a duration of 2 minutes
   **Generalization Criteria: Generalization Across Contexts / Environments**
   **Goal Attainment Scale Score:** 1 - Some progress within reporting period - Goal not met
   **Progress:** Tyler will tolerate a peer sitting/ standing within a 6-foot distance during a play activity for a duration of 5 minutes across 3 consecutive weeks.
   **Graphic Display:**



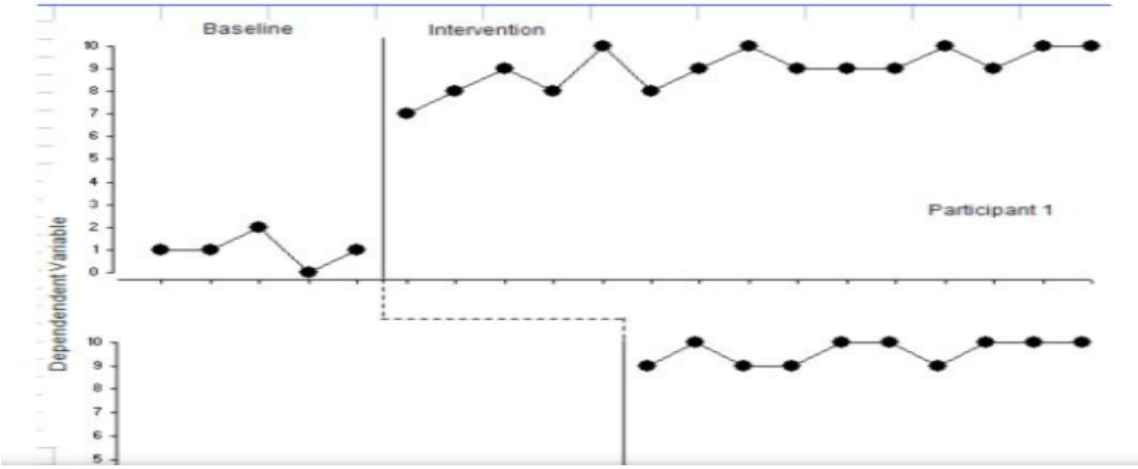
**SELF HELP / DAILY LIVING SKILLS**

Skills in this domain focus on activities of daily living including developmentally appropriate personal independence (eating, dressing, hygiene, household responsibilities), safety, play and leisure (independent and with adult and peer partners), and community skills.

4. **Treatment Goal: (within six-months)** Tyler will hold and maintain contact with caregiver while crossing the street when parent holds out their hand for Tyler to grab on to.
   **Goal Status:** On Hold
   **Assessment Tool Source:** EFL Domain 6 T-PEMR10a
   **Baseline Date and Brief Description: 1/1/2022** Tyler holds and maintains contact with parents while crossing the street when parents take his hand and say, "hold my hand, please" (or similar statement)
   **Generalization Criteria: All of the above**
   **Goal Attainment Scale Score:** 1 - Some progress within reporting period - Goal not met
   **Progress:** Tyler will hold and maintain contact with his mother and father while crossing the street when his parents hold out their hand for Tyler to grab on to and say, "hold my hand, please," (or similar statement). This goal will be placed on hold due to parent request.
   **Graphic Display:**



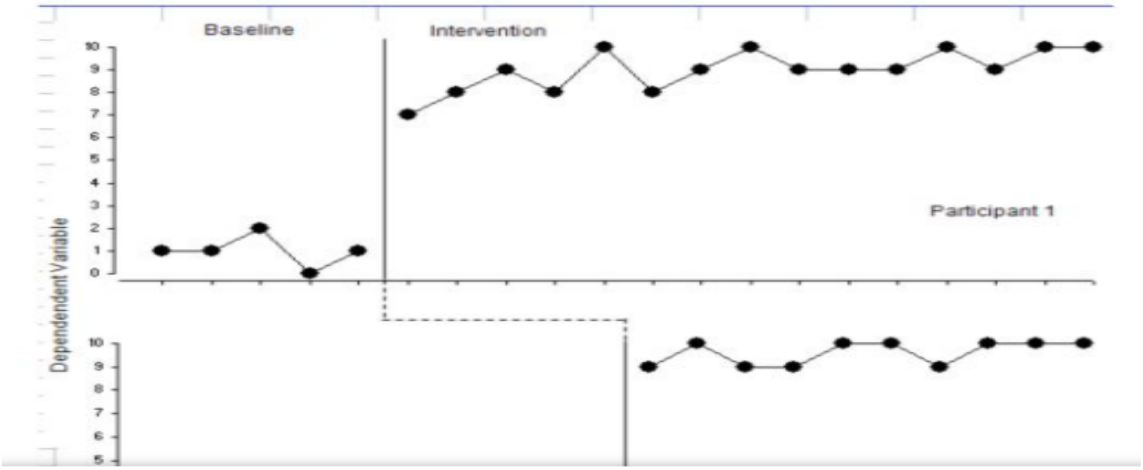

5. **Treatment Goal: (within six-months)** Tyler will tolerate wearing a mask for at least 30 minutes across both parents and at least 2 settings ( i.e. home, park, target, etc.)
   **Goal Status:** Met
   **Assessment Tool Source: EFL Domain 6 T-PEMR10a**
   **Baseline Date and Brief Description: 1/1/2022** Tyler will tolerate wearing a mask for 5 minutes at home and at Target
   **Generalization Criteria: All of the above**
   **Goal Attainment Scale Score:** 2 - Expected outcome - Goal met
   **Progress:** Tyler will tolerate wearing a mask for at least 30 minutes across both parents and at least 2 settings (i.e. home and target).
   **Graphic Display:**




**BEHAVIOR**

This domain focuses on behavioral excesses and skill deficits, which pose a risk to the client or others, or present a clinically significant need for intervention.

6. **Treatment Goal: (within six-months)** Tyler will refrain from engaging in face hitting in 40% of opportunities of being denied a preferred item.
   **Goal Status:** Met
   **Assessment Tool Source:** FAST
   **Baseline Date and Brief Description: 1/1/2022** Tyler will hit himself with an open hand 100% of the time when denied, tablet or other preferred items
   **Generalization Criteria: Generalization to Parents/Caregivers**
   **Goal Attainment Scale Score:** 3- - Somewhat more than expected outcome - Goal met
   **Progress:** Tyler will refrain from engaging in face hitting in 80% of opportunities of being denied a preferred item.
   **Graphic Display:**




7. **Treatment Goal: (within six-months)** Tyler will refrain from engaging in face hitting in 100% of opportunities of being denied a preferred item.
   **Goal Status:** New Goal
   **Assessment Tool Source:** FAST
   **Baseline Date and Brief Description: 6/1/2022** Tyler will hit himself with an open hand 20% of the time when denied, tablet or other preferred items
   **Generalization Criteria: Generalization to Parents/Caregivers**
   **Goal Attainment Scale Score:** New Goal
   **Progress:** NA
   **Graphic Display:**

**FUNCTIONAL BEHAVIOR ASSESSMENT AND BEHAVIOR PLAN (IF APPLICABLE)**
**Is physical intervention clinically indicated? ☐ Yes ☐ No**
ABC DE FGHIJ K LM NOP QRS T UVWX YZ. ABC DE FGHIJ K LM NOP QRS T UVWX YZ
**If physical intervention is clinically indicated, has the intervention in this treatment plan been reviewed and approved by the CCS? ☐ Yes ☐ No**
NA
**Has the intervention been reviewed with parent/caregiver/client and are they in agreement with described intervention? ☐ Yes ☐ No**
Click or tap here to enter text.
**If Dangerous Behaviors are Present, list assessment tool source(s) used**

**FAST**

**Behavior Support Plan (if indicated):**

ABC DE FGHIJ K LM NOP QRS T UVWX YZ. ABC DE FGHIJ K LM NOP QRS T UVWX YZ.

**BEHAVIORAL CRISIS PLAN:**

ABC DE FGHIJ K LM NOP QRS T UVWX YZ. ABC DE FGHIJ K LM NOP QRS T UVWX YZ.

**CAREGIVER TRAINING**

This domain is focused on education for caregivers. Goals are developed in collaboration with the caregivers and reflect their identified needs and priorities.

**Caregiver Participation**

Compliance with treatment recommendations and active parent/caregiver participation is essential to optimal client progress in programs. Treatment aims at empowering parent(s)/caregiver(s) to independently carry over strategies to their daily lives thus enabling independence and fulfillment for the client and their family.

8. **Treatment Goal: (within six-months)** Tyler's parents will design and implement a reinforcement system in collaboration with the clinical team to teach Tyler at least 5 new safety skills in 1 community setting.
   **Goal Status:** New Goal
   **Assessment Tool Source: Parent Concern**
   **Baseline Date and Brief Description: 6/1/2022** Tyler's parents have identified 3 preferred items that can be used as part of a reinforcement system
   **Generalization Criteria: Generalization Across Contexts / Environments**
   **Goal Attainment Scale Score:** New Goal
   **Progress:** NA
   **Graphic Display:**

9. **Treatment Goal: (within six-months) Tyler's parents will implement 100% of the steps in the nighttime/ sleeping protocol (e.g., bedtime pass) with 60% integrity as measured by parent collected data across at least 4 consecutive weeks.**
   **Goal Status:** Met
   **Assessment Tool Source: Parent Concern**
   **Baseline Date and Brief Description: 6/1/2022 Tyler's parents reported they present Tyler with a structured sleep routine ( i.e., dinner at 6:30pm, shower by 7:00pm in bed by 7:45pm) 3 out of 7 days of the week.**
   **Generalization Criteria: Generalization Across Contexts / Environments**
   **Goal Attainment Scale Score:** 4 - Much more than expected outcome - Goal met
   **Progress: Tyler's parents implemented 100% of the steps associated with a structured nighttime routine, consisting of: 3 nightly choices for wind down activities, a consistent bedtime of 8pm & the allowance of 2 bedtime passes with 90% integrity across 4 consecutive weeks.**
   **Graphic Display:**

**SUMMARY**

**SUMMARY OF PROGRESS**
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| **BARRIERS TO SERVICE** | **Environmental or family concerns that are likely to have significantly impacted service delivery in the last treatment period.**<br>☐ Yes<br>☒ No |
| **DOES CLIENT EXHIBIT DANGEROUS BEHAVIORS (inclusive of any dangerous behaviors observed during or outside of treatment)?**<br>**☐ Yes ☒ No** | **If "Yes," please select all that apply:**<br>☐ **Self-injurious behavior** that could result in the need for first aid or medical attention<br>• Age or date of onset (estimated) Choose an item. Click or tap to enter a date.<br>• Frequency: Choose an item.<br>• Intensity: Choose an item. |

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| **Behavior Support Plan (BSP) to be implemented (see BSP above)?**<br><br>☐ **Yes** ☐ **No**<br>**If "No," Rationale:**<br><br>Click or tap here to enter text. | ☐ **Physical harm to others** that could result in the need for first aid or medical attention<br>• Age or date of onset (estimated) Choose an item. Click or tap to enter a date.<br>• Frequency: Choose an item.<br>• Intensity: Choose an item.<br>☐ **Dangerous elopement** that is not age-appropriate and could result in injury<br>• Age or date of onset (estimated) Choose an item. Click or tap to enter a date.<br>• Frequency: Choose an item.<br>• Intensity: Choose an item.<br>☐ **Sexually inappropriate behavior** that could result in physical harm, serious complaint from others or law enforcement involvement<br>• Age or date of onset (estimated) Choose an item. Click or tap to enter a date.<br>• Frequency: Choose an item.<br>• Intensity: Choose an item.<br>☐ **Property destruction** that could result in law enforcement involvement<br>• Age or date of onset (estimated) Choose an item. Click or tap to enter a date.<br>• Frequency: Choose an item.<br>• Intensity: Choose an item.<br>☐ **Eating food or non-food items** that is not age-appropriate and could result in medical attention<br>• Age or date of onset (estimated) Choose an item. Click or tap to enter a date.<br>• Frequency: Choose an item.<br>• Intensity: Choose an item.<br>☐ **Behaviors connected to elimination** that could result in physical harm or are severely socially inappropriate |

| | |
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| | • Age or date of onset (estimated) Choose an item. Click or tap to enter a date.<br>• Frequency: Choose an item.<br>• Intensity: Choose an item.<br>☐ **Other** behaviors that might lead to physical harm or lead to law enforcement involvement<br>< insert description ><br>• Age or date of onset (estimated) Choose an item. Click or tap to enter a date.<br>• Frequency: Choose an item.<br>• Intensity: Choose an item. |

**EMERGENCY / CRISIS PLAN**

In the event of an unexpected crisis during sessions, treatment staff will follow the general guidelines outlined below:

- Responsible adult oversees client safety
- Treatment staff will ensure safety of self
- If the Responsible adult is unavailable or unable to help, treatment staff will assist by calling 911 if appropriate and possible
- Treatment staff will inform supervisor of the incident as soon as possible
- Immediate notification to the CCS and submission of a Reportable Event within 1 business day of the incident

**GOAL ATTAINMENT SCALE OVERALL PROGRESS**

| *** Includes acquisition, behavior reduction & caregiver training goals.**<br><br>**Do not include goals that are new, on hold or discontinued.** | **Total # of Goals for Client & Caregiver** |
|---|---|
| Goals at 0 (Not Met - No Progress within Reporting Period) | |
| Goals at 1 (Not Met - Some Progress within Reporting Period) | 1 |
| Goals at 2 (Goal Met - Expected outcome) | 1 |
| Goals at 3 (Goal Met - Somewhat more than expected outcome) | 1 |
| Goals at 4 (Goal Met - Much more than expected outcome) | 2 |
| Total Goals Met Score (add goals scored 2, 3, & 4 on GAS) | 4 |

| | |
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| Total Percentage of Goals Met (total goals met divided by ALL goals listed above) | 80 % |

**TOTAL GOALS FOR CLIENTS & CAREGIVER**

| | |
|---|---|
| **Total Goals: met, continued, revised, on hold, or discontinued** | 6 |
| **Count of New Goals Added for Next Reporting Period** | 3 |

**ANTICIPATED DISCHARGE DATE: 6/1/2023**

**FADE PLAN *(required if anticipated discharge date is within 6 months):***

Click or tap here to enter text.

**ANTICIPATED DISCHARGE DATE CHANGED SINCE LAST REPORT? Yes ☐ No ☒**

**REASON FOR CHANGE:** Click or tap here to enter text.

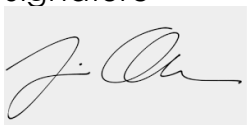
| **Guidelines for Discharge from ABA Episode of Care** | |
|---|---|
| ***Discharge: Episode of Care Complete*** | ***Discharge: ABA not appropriate or no longer appropriate*** |
| ▪ Cognitive potential has been reached and no significant life interfering maladaptive behaviors are present OR<br><br>▪ The client has achieved adequate stabilization and behaviors can be managed in a less intensive treatment/environment OR<br><br>▪ The client can be treated with a less intensive level of care (e.g., community social program) OR<br><br>▪ Behavior change is meaningful and sustainable | • Improvements are not maintained or generalized OR<br><br>• There is a lack of meaningful progress (e.g., no change in adaptive domains) OR<br><br>• Treatment is making the symptoms persistently worse (e.g., maladaptive behavior occurs more during ABA sessions; a trial of stopping ABA results in improved behavior) OR<br><br>• Client becomes too fatigued with school/Day Program and ABA OR<br><br>• Family members / caregivers are unable to support ABA and **no or minimal progress** has been made as a result (e.g., |

| | |
|---|---|
| (see definition of meaningful change) OR<br><br>▪ Behavior is within normal limits when compared to peers without ASD who have a similar intellectual level | excess cancelations result in no progress). ***NOTE:*** *Discharge is based on progress not parent participation. Before discharge every effort should be made to support family/parents so that ABA can continue* OR<br><br>• Client is 12 or older and has the ability to decline ABA (e.g., is able to express their desire to stop ABA) OR<br><br>• Behavior is more related to non-ASD mental health symptoms such as an anxiety disorder |

| **Treatment Plan Review Date with Family:**<br>(Provider met with client/family to provide update and obtain their input on treatment)<br>*NOTE: Ensure client/family is provided a copy of this report following its authorization.* | |
|---|---|
| **Report Reviewed with Client/Family?** | Yes ☒ 5/28/2022 |
| | No ☐ Reason: Click or tap here to enter text. |

**Please contact us or your CCS Clinical Case Manager at 855-843-2476 directly with any additional questions or comments related to this report.**

Respectfully Submitted,

| | | | |
|---|---|---|---|
|  | Rebeca Nelly, High Level Supervisor | XYZ | 6/1/2022 |
| Signature | Print Name and Title | License/Cert.# | Date |
|  | Jessica Felt, Mid Level Supervisor | XYZ | 6/1/2022 |
| Signature | Print Name and Title | License/Cert.# | Date |