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.

Assessment Report

Assessment conducted in the following setting:
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: *(e.g., 02 years, 08 months)*	Click or tap here to enter text.
Client's Race / Ethnicity	Click or tap here to enter text.
Client's Gender **Client's Pronouns**	Click or tap here to enter text. 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: **Client Address if Different Than Parent/Legal Guardian:**	Click or tap here to enter text. Click or tap here to enter text.
Out of (Funder) Service Area (OOSA) Yes or No: *(If Yes, provide treatment location)*	Click or tap here to enter text.
Phone Number:	Click or tap here to enter text.
Treatment Team:	Click or tap here to enter text.

Include contact email and phone for supervisor)	
Diagnosis (listed on authorization)**:**	Click or tap here to enter text.
Diagnosing MD or Psychologist Name AND Date of Diagnosis(es) *(If not ASD Client, use the referring physician)*	Click or tap here to enter text.
Projected Offer of BHT :	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: Choose an item.

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

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

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

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.

Practitioner Mediated Treatment Option

Choose an item.

Practitioner Mediated hours will begin after initial caregiver training has occurred for (#) weeks.

Practitioner Level	Service Type	Hours	Location of Services
Direct Level Practitioner – H2019	Direct	**Range of Hours** (-) Hours/Week	Home ☒ Clinic/Center ☐ Community ☐ Telehealth ☐ Other Setting ☐ Click or tap here to enter text.
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.

Recommendation Rationale:
Click or tap here to enter text.

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

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

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 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**
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.

HISTORY & SUMMARY OF SERVICES

FAMILY CONSTELLATION

Click or tap here to enter text.

SIGNIFICANT BIRTH & MEDICAL HISTORY

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

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

PREFERENCE ASSESSMENT

Click or tap here to enter text.

BEHAVIORAL ASSESSMENT

Click or tap here to enter text.

ADAPTIVE BEHAVIOR ASSESSMENT

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

Click or tap here to enter text.

The Vineland Adaptive Scales, 3rd edition is conducted to assess an 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					
Motor Skills *(optional)*					
Fine Motor					
Gross Motor					
Maladaptive Behavior (optional)					
Internalizing					
Externalizing					
Other					
Adaptive Behavior Composite					

ASSESSMENT RESULTS

Click or tap here to enter text.

SLEEP CHECKLIST	
Is sleep/bedtime a significant problem?	Choose an item. If **Yes**, answer questions below
Goals for Sleep/Bedtime	
Caregiver training goals addressing sleep/bedtime	Choose an item. If **No**, provide a clinical rationale: Click or tap here to enter text.
Sleep goals addressed	☐ Difficulty falling asleep ☐ Frequent waking & stays awake ☐ Problem behaviors associated with bedtime ☐ Excessive daytime sleepiness *(not associated with a medical condition* ☐ 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

RECEPTIVE COMMUNICATION

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

Strengths:

-
-
-

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.

EXPRESSIVE COMMUNICATION

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

Strengths:

-
-
-

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.

PRAGMATIC COMMUNICATION

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

Strengths:

-
-
-

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.

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:

-
-
-

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.

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:

-
-
-

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.

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:

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:

-
-
-

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.

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.** ☐ Yes ☐ No
DOES CLIENT EXHIBIT DANGEROUS BEHAVIORS (inclusive of any dangerous behaviors observed during or outside of treatment)? **☐ Yes ☐ No** **Behavior Support Plan (BSP) to be implemented (see BSP above)?** **☐ Yes ☐ No** **If "No," Rationale:**	**If "Yes," please select all that apply:** ☐ **Self-injurious behavior** that could result in the need for first aid or medical attention • Age or date of onset (estimated) Choose an item. Click or tap to enter a date. • Frequency: Choose an item. • Intensity: Choose an item. ☐ **Physical harm to others** that could result in the need for first aid or medical attention • Age or date of onset (estimated) Choose an item. Click or tap to enter a date. • Frequency: Choose an item. • Intensity: Choose an item. ☐ **Dangerous elopement** that is not age-appropriate and could result in injury • Age or date of onset (estimated) Choose an item. Click or tap to enter a date. • Frequency: Choose an item.

Click or tap here to enter text.	• Intensity: Choose an item. ☐ **Sexually inappropriate behavior** that could result in physical harm, serious complaint from others or law enforcement involvement • Age or date of onset (estimated) Choose an item. Click or tap to enter a date. • Frequency: Choose an item. • Intensity: Choose an item. ☐ **Property destruction** that could result in law enforcement involvement • Age or date of onset (estimated) Choose an item. Click or tap to enter a date. • Frequency: Choose an item. • Intensity: Choose an item. ☐ **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. • Frequency: Choose an item. • Intensity: Choose an item. ☐ **Behaviors connected to elimination** that could result in physical harm or are severely socially inappropriate • Age or date of onset (estimated) Choose an item. Click or tap to enter a date. • Frequency: Choose an item. • Intensity: Choose an item. ☐ **Other** behaviors that might lead to physical harm or lead to law enforcement involvement < insert description > • Age or date of onset (estimated) Choose an item. Click or tap to enter a date. • 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 CCS and submission of a Reportable Event Form within 1 business day of the incident

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

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 ▪ The client has achieved adequate stabilization and behaviors can be managed in a less intensive treatment/environment OR ▪ The client can be treated with a less intensive level of care (e.g. community social program) OR ▪ Behavior change is meaningful and sustainable (see definition of meaningful change) OR ▪ Behavior is within normal limits when compared to peers without ASD who have a similar intellectual level	• Improvements are not maintained or generalized OR • There is a lack of meaningful progress (e.g. no change in adaptive domains) OR • 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 • Client becomes too fatigued with school/Day Program and ABA OR • 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 • Client is 12 or older and has the ability to decline ABA (e.g. is able to express their desire to stop ABA) OR • Behavior is more related to non-ASD mental health symptoms such as an anxiety disorder

Treatment Plan Review Date with Family: (Provider met with client/family to provide update and obtain their input on treatment) *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
	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