CATALIGHT
CARE SERVICES

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

Discharge / Transfer Report

Select Service Line
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: *Include contact email and phone for supervisor)*	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) *(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: 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.

** *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 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.

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** (-) 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)
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)
Choose an item.
Click or tap here to enter text.

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 ▪ 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	• 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

▪ 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	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

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 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.

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 any other professionals that support the family.

SLEEP CHECKLIST **Inclusion of Caregiver Report & Progress on Sleep Goals**	
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.
Progress	
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.
Goal Attainment Scale Score: Choose an item.
Progress: Click or tap here to enter text.
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)** 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.
   Goal Attainment Scale Score: Choose an item.
   Progress: Click or tap here to enter text.
   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)** 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.
   Goal Attainment Scale Score: Choose an item.
   Progress: Click or tap here to enter text.
   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)** 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.
   Goal Attainment Scale Score: Choose an item.
   Progress: Click or tap here to enter text.
   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.

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

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.

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

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.** ☐ Yes ☐ No
DOES CLIENT EXHIBIT DANGEROUS BEHAVIORS (inclusive of any dangerous behaviors observed during or outside of treatment)? **☐ Yes ☐ No**	**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.

Behavior Support Plan (BSP) to be implemented (see BSP above)? ☐ **Yes** ☐ **No** **If "No," Rationale:** Click or tap here to enter text.	• 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. • 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

GOAL ATTAINMENT SCALE OVERALL PROGRESS

*** Includes acquisition, behavior reduction & caregiver training goals. Do not include goals that are new, on hold or discontinued.**	**Total # of Goals for Clients & Caregivers**
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 CLIENTS & CAREGIVER

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

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.

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
	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