theBHPN

behavioral health provider network

Report Authoring & Submission Guide

Effective: January 1, 2022

Required in Header: Client Name, MRN, Date of Report (on all pages) – Note that when a revision is needed to the report, ensure that you change the date of the report in the header and the *Date of Report* on the signature line on the last page to indicate an updated/revised version.

Introduction

Introduction to the Report Authoring and Submission Guide

The Behavioral Health Provider Network (BHPN) 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 BHPN Provider Manual in the event they relate to requirements of reporting and documentation.

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

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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** **If this was not provided, obtain information from client/family**	Click or tap here to enter text.

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Client's Gender **Client's Pronouns** **Reference clinical documents sent in BHT** **If this was not provided, obtain information from client/family**	Choose an item. 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: **Indicate caregiver or client's phone number**	Click or tap here to enter text.
Treatment Team: *Include contact email and phone for supervisor)* **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) *(If not ASD Client, use the referring physician)*	Click or tap here to enter text.
Projected 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: (Reference clinical documents sent e.g., BHT IA, DE)
Click or tap here to enter text.

BHPN 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.

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The following recommendations are being made:
Choose an item.

Intervention should consist of:

_____ Recommended Hours of direct service (H2019) per week. ***(Optimal Hours*** *clinically recommended for treatment)*

_____ Requested Hours of direct service (H2019) per week for new authorization period. ***(Beneficial Hours*** *accepted by the family. Treatment plan should be based on Beneficial Hours)*

Difference between requested and recommended hours if applicable:
Click or tap here to enter text.

Authorization Request (Hours agreed to by client/family)

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

Practitioner Level	**Service Type**	**Hours**	**Location of Services** **Any one of the marked off service locations could be clinically appropriate or could occur in one or all these settings.**
Direct Level Practitioner – H2019	Direct	___ 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/Week	Home ☐ Clinic/Center ☐ Community ☐ Telehealth ☐ Other Setting ☐ Click or tap here to enter text.

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High Level Supervisor – H0004	Direct & Indirect	___ Hours/Week	Home ☐ Clinic/Center ☐ Community ☐ Telehealth ☐ Other Setting ☐ Click or tap here to enter text.

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 BHPN 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, BHPN 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.

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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, BHPN 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 BHPN 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

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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.

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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.

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.

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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.

-
-
-

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.

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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.

-
-
-

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 the BHPN? ☐ Yes ☐ No
Click or tap here to enter text.

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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 BHPN 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.

-
-
-

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.

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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 **Examples could include:** • **Significant changes in family (e.g., divorce, remarriage, new siblings, moving, death in the family)** • **Illness, mental illness, or other disabilities in the family (other than the client)** • **Socioeconomic insecurity (e.g., poverty, immigration issues, housing issues, unsafe neighborhood)** • **Changes in school placement** • **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 BHPN Clinical Case Manager for support.**
DOES CLIENT EXHIBIT DANGEROUS BEHAVIORS (inclusive of any dangerous behaviors observed during or outside of treatment)? **☐ Yes ☐ No** **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:** ☐ **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

Behavior Support Plan (BSP) to be implemented (see BSP above)? **☐ Yes ☐ No** **If "No," Rationale:** Click or tap here to enter text.	• 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 the BHPN and submission of a Reportable Event Form to theBHPN@theBHPN.org within 1 business day of the incident

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 ▪ 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

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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 **the BHPN Clinical Case Manager** at 855-843-2476 (855-the-BHPN) 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 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

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

Progress Report

Choose an item.

Choose an item.

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** **If this was not provided, obtain information from client/family**	Click or tap here to enter text.
Client's Gender **Client's Pronouns** **Reference clinical documents sent in BHT** **If this was not provided, obtain information from client/family**	Choose an item. 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.

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Indicate caregiver or client's phone number	
Treatment Team: *Include contact email and phone for supervisor)* **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) *(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: (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.

Intervention should consist of:

_____ Recommended Hours of direct service (H2019) per week. ***(Optimal Hours*** *clinically recommended for treatment)*

_____ Requested Hours of direct service (H2019) per week for new authorization period. ***(Beneficial Hours*** *accepted by the family. Treatment plan should be based on Beneficial Hours)*

Difference between requested and recommended hours if applicable:
Click or tap here to enter text.

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Authorization Request (Hours agreed to by client/family)

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

Practitioner Level	**Service Type**	**Hours**	**Location of Services** **Any one of the marked off service locations could be clinically appropriate or could occur in one or all these settings.**
Direct Level Practitioner – H2019	Direct	__ 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/Week	Home ☐ Clinic/Center ☐ Community ☐ Telehealth ☐ Other Setting ☐ Click or tap here to enter text.
High Level Supervisor – H0004	Direct & Indirect	__ Hours/Week	Home ☐ Clinic/Center ☐ Community ☐ Telehealth ☐ Other Setting ☐ Click or tap here to enter text.

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 BHPN and educational personnel**

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- **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, BHPN 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.

CURRENT AUTHORIZATION

Current Authorization Treatment Start / End Date: Click or tap to enter a date. - Click or tap to enter a date.	
Service	**Intensity**
Direct Service Practitioner – H2019 (weekly)	__ 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	**Intensity**
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

Required in Header: Client Name, MRN, Date of Report (on all pages) – Note that when a revision is needed to the report, ensure that you change the date of the report in the header and the *Date of Report* on the signature line on the last page to indicate an updated/revised version.

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.**

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:

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(Other Behavioral Health Treatment, supplementary services, BHPN 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 BHPN 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.

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.

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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)

Required in Header: Client Name, MRN, Date of Report (on all pages) – Note that when a revision is needed to the report, ensure that you change the date of the report in the header and the *Date of Report* on the signature line on the last page to indicate an updated/revised version.

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.

Required in Header: Client Name, MRN, Date of Report (on all pages) – Note that when a revision is needed to the report, ensure that you change the date of the report in the header and the *Date of Report* on the signature line on the last page to indicate an updated/revised version.

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 the BHPN? ☐ 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.

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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 BHPN 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.** ☐ Yes ☐ No **Examples could include:** • **Significant changes in family (e.g., divorce, remarriage, new siblings, moving, death in the family)**

	• **Illness, mental illness, or other disabilities in the family (other than the client)** • **Socioeconomic insecurity (e.g., poverty, immigration issues, housing issues, unsafe neighborhood)** • **Changes in school placement** • **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 BHPN Clinical Case Manager for support.**
DOES CLIENT EXHIBIT DANGEROUS BEHAVIORS (inclusive of any dangerous behaviors observed during or outside of treatment)? **☐ Yes ☐ No** **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.** **Behavior Support Plan (BSP) to be implemented (see BSP above)?** **☐ Yes ☐ No** **If "No," Rationale:** Click or tap here to enter text.	**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. • 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 the BHPN and submission of a Reportable Event Form to theBHPN@theBHPN.org 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 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)	

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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 ▪ 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.

Please contact us or your BHPN Clinical Case Manager at 855-843-2476 (855-the-BHPN) 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 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

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

Discharge / Transfer Report

Choose an item.
Choose an item.

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** **If this was not provided, obtain information from client/family**	Click or tap here to enter text.
Client's Gender **Client's Pronouns** **Reference clinical documents sent in BHT** **If this was not provided, obtain information from client/family**	Choose an item. 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: **Indicate caregiver or client's phone number**	Click or tap here to enter text.

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Treatment Team: *Include contact email and phone for supervisor)* **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) *(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.

The following recommendations are being made:
Choose an item.

Intervention should consist of:

_____ Recommended Hours of direct service (H2019) per week. ***(Optimal Hours*** *clinically recommended for treatment)*

_____ Requested Hours of direct service (H2019) per week for new authorization period. ***(Beneficial Hours*** *accepted by the family. Treatment plan should be based on Beneficial Hours)*

Difference between requested and recommended hours if applicable:
Click or tap here to enter text.

Required in Header: Client Name, MRN, Date of Report (on all pages) – Note that when a revision is needed to the report, ensure that you change the date of the report in the header and the *Date of Report* on the signature line on the last page to indicate an updated/revised version.

Authorization Request (Hours agreed to by client/family)

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

Practitioner Level	**Service Type**	**Hours**	**Location of Services** **Any one of the marked off service locations could be clinically appropriate or could occur in one or all these settings.**
Direct Level Practitioner – H2019	Direct	__ 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/Week	Home ☐ Clinic/Center ☐ Community ☐ Telehealth ☐ Other Setting ☐ Click or tap here to enter text.
High Level Supervisor – H0004	Direct & Indirect	__ Hours/Week	Home ☐ Clinic/Center ☐ Community ☐ Telehealth ☐ Other Setting ☐ Click or tap here to enter text.

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 BHPN and educational personnel**

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- **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, BHPN 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	**Intensity**
Direct Service Practitioner – H2019 (weekly)	__ 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	**Intensity**
Direct Service Practitioner – H2019 (weekly)	__ Hours/Week
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Mid-Level Supervisor– H0032 (monthly)	__ Hours/Month
High-Level Supervisor– H0004 (monthly)	__ Hours/Month

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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 ▪ 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

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.

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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, BHPN 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 BHPN 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.

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 BHPN? ☐ Yes ☐ No
Click or tap here to enter text.

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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 BHPN 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

Required in Header: Client Name, MRN, Date of Report (on all pages) – Note that when a revision is needed to the report, ensure that you change the date of the report in the header and the *Date of Report* on the signature line on the last page to indicate an updated/revised version.

(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.** ☐ Yes ☐ No **Examples could include:** • **Significant changes in family (e.g., divorce, remarriage, new siblings, moving, death in the family)** • **Illness, mental illness, or other disabilities in the family (other than the client)** • **Socioeconomic insecurity (e.g., poverty, immigration issues, housing issues, unsafe neighborhood)** • **Changes in school placement** • **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 BHPN Clinical Case Manager for support.**
DOES CLIENT EXHIBIT DANGEROUS BEHAVIORS (inclusive of any dangerous behaviors observed during or outside of treatment)? **☐ Yes ☐ No** **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:** ☐ **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

Behavior Support Plan (BSP) to be implemented (see BSP above)? **☐ Yes ☐ No** **If "No," Rationale:** Click or tap here to enter text.	• 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 the BHPN and submission of a Reportable Event Form to theBHPN@theBHPN.org 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 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: (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 BHPN Clinical Case Manager at 855-843-2476 (855-the-BHPN) 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 This date should match the date in the header.

Required in Header: Client Name, MRN, Date of Report (on all pages) – Note that when a revision is needed to the report, ensure that you change the date of the report in the header and the *Date of Report* on the signature line on the last page to indicate an updated/revised version.

	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

Required in Header: Client Name, MRN, Date of Report (on all pages) – Note that when a revision is needed to the report, ensure that you change the date of the report in the header and the *Date of Report* on the signature line on the last page to indicate an updated/revised version.

Addendum Report

Select Service Line

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.

The following recommendations are being made:
Choose an item.

Intervention should consist of:
_____ Recommended Hours of direct service (H2019) per week. ***(Optimal Hours*** *clinically recommended for treatment)*
_____ Requested Hours of direct service (H2019) per week for new authorization period. ***(Beneficial Hours*** *accepted by the family. Treatment plan should be based on Beneficial Hours)*

Difference between requested and recommended hours if applicable:
Click or tap here to enter text.

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Authorization Request (Hours agreed to by client/family)

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

Practitioner Level	**Service Type**	**Hours**	**Location of Services** **Any one of the marked off service locations could be clinically appropriate or could occur in one or all these settings.**
Direct Level Practitioner – H2019	Direct	__ 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/Week	Home ☐ Clinic/Center ☐ Community ☐ Telehealth ☐ Other Setting ☐ Click or tap here to enter text.
High Level Supervisor – H0004	Direct & Indirect	__ Hours/Week	Home ☐ Clinic/Center ☐ Community ☐ Telehealth ☐ Other Setting ☐ Click or tap here to enter text.

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).**

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- **If an educational setting is clinically recommended the following is needed:**
  - **Rationale for medical necessity**
  - **Coordination of care is needed with the BHPN 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, BHPN 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 BHPN can be found in the Appendix of the BHPN 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

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(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 BHPN? ☐ Yes ☐ No

Click or tap here to enter text.

Required in Header: Client Name, MRN, Date of Report (on all pages) – Note that when a revision is needed to the report, ensure that you change the date of the report in the header and the *Date of Report* on the signature line on the last page to indicate an updated/revised version.

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 BHPN 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:

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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.** ☐ Yes ☐ No **Examples could include:** • **Significant changes in family (e.g., divorce, remarriage, new siblings, moving, death in the family)** • **Illness, mental illness, or other disabilities in the family (other than the client)** • **Socioeconomic insecurity (e.g., poverty, immigration issues, housing issues, unsafe neighborhood)** • **Changes in school placement** • **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 BHPN Clinical Case Manager for support.**
DOES CLIENT EXHIBIT DANGEROUS BEHAVIORS? (Inclusive of any dangerous behaviors observed during or outside of treatment)? **☐ Yes ☐ No** **Dangerous behaviors are a subset of maladaptive or problem behaviors; severe behaviors that could result**	**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

in physical injury requiring first aid or medical attention or behaviors that could result in law enforcement involvement. **Behavior Support Plan (BSP) to be implemented (see BSP above)?** **☐ Yes ☐ No** **If "No," Rationale:** Click or tap here to enter text.	• 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.

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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 BHPN Clinical Case Manager at 855-843-2476 (855-the-BHPN) 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 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