BEHAVIOR TREATMENT PLAN

The provider is not required to use this plan of care form. However, if not using this form, the plan of care must address all the information specified in the Medicaid State Plan for Applied Behavior Analysis (ABA) and the most recent version of the ABA Provider Manual.

Recipient

Type or print the patient's full name, Medicaid ID number, date of birth, address and home and cell phone number in the space provided.

Provider Information

Type or print the name of the provider, the provider's Medicaid ID number, phone number, address and contact person's email address.

Medical Reason Supporting the Need for ABA Services

Type or print the recipient's diagnosis.

Requested Hours of Services

- Type or print the number of tutor/RBT hours requested per week.
- Type or print the number of supervision hour conducted by the (BCBA/-D) per week.
- Type or print the number of direct services hour provided by a BCBA/-D per week (this may include caregiver training as well).
- Type or print the total number of requested hours for all services per week.

Baseline Level of Behaviors Addressed in the Plan Based on Assessment Results

- Type or write a narrative description of the baseline level of all behaviors assessed for which a goal is developed. **This section must be completed.**

Examples:

- "Daniel did not use words to communicate during the assessment.";
- "James used ten mand forms inconsistently during assessment.";
- "Sharlee could tact ten animals and four colors during assessment."; and
- "Silvia made eye-contact two of 12 times after given the direction, look at me."

- If the document is a treatment plan renewal, list the present level of performance for skills under treatment and any goals mastered during the previous authorization period.

- Do not refer to idiosyncratic, proprietary assessment instrument results to describe baseline performance.

Examples:

- "Harry could perform skills 4L to 5G on ABEL4 assessment"; and
- "Wilma performed at a level 2 across all language skills on VBMZT assessment."

NOTE: May use another sheet for this section and attach it to this form, but the section must be labeled.

Treatment Goals

- Type or write a goal for each behavior/skill identified for treatment not including behavior reduction goals. Each goal should have a performance standard and criterion for mastery.

Examples

- "Jon will tact 26 upper case letters independently across two consecutive treatment sessions;
- "Susan will use quantifying autoclitics while manding for chips, (e.g., Can I have two chips please) for ten mand forms."; and
- "Marvin will make eye contact when his name is called on 90% of the instructional trials across three tutors."

- The provider may NOT use idiosyncratic, proprietary nomenclature to specify treatment goals.

  Examples:

  - "Seth will complete goals A-K, M-R, and Q-T on the MASP.";
  - "Roger will master ADL skills 1-2 to 4-6 on the ACQMOT program."

NOTE: A separate sheet may be used for this section and attach it to this form, but the section must be labeled.

Behavior Reduction Plan

According to state guidelines, if the provider is going to intervene on problem behaviors, the provider MUST conduct a functional assessment or a functional analysis (preferred method) and develop a function based treatment plan.

- The provider may NOT make a grid sheet with intervention tactics that is not tied to a narrative description/date analysis of the results of a functional assessment/analysis.

- Type or write the behavior topography of the problem behavior and state the frequency/duration/latency/intensity of all the problem behaviors for which a goal is developed.

- Type or write the results of the functional assessment and type or write a hypothesis statement or describe the results of a functional analysis.

- Type or write a behavior improvement goals with a performance standard and criteria for mastery.

  Examples:

  - "Terrance will decrease hitting others by 50 percent week for four consecutive weeks. Terrance will ask mand for attention by saying "help" when prompted on 100 percent of the opportunities."; and
  - "William ask mand for an independently break at least five times/session."

- Type or write the behavior intervention plan that addresses the function of the problem behavior that includes strengthening a functional replacement behavior.

Parent/guardian training and support goals

Type or write caregiver training with a performance standard and criteria for mastery.

Example:

- After role-play training, Mrs. Jones will implement Terrance's behavior reduction plan with 100 percent fidelity across three sessions

Statement of justification for ABA Therapy Hours Requested

Type or write the specific criteria used to determine the need for ABA therapy at the hours requested.

Example:

- Terrance presents with clinically significant deficits in listener behavior (receptive identification, direction following) and currently does not use vocal verbal, sign language or augmentative communication to communicate. He engages in high frequency and high intensity aggressive and self-injurious behavior that presents a substantial risk to himself, others, and property.

Predominant Location

Specify the predominant location where all services will take place.

Check off the environment where services will occur. If services will occur in more than one setting, you may check more than one box.

Hours of Service

Specify the hours of service each day during the school year and summer (if necessary).

Type or write the anticipated total hours (therapy + supervision) for each day.

Signatures

Provide signatures as necessary. **Must sign and date the plan.**

Plan of Care Form

The form below may be used to document the POC. For a copy of this form in Microsoft Excel format please contact the ABA Program Manager, Rene Huff, at 225-342-3935 or at Rene.Huff@la.gov.

NOTE: Use of this POC form is not required. However, ALL POCs must address all of the information specified in the Medicaid State Plan for Applied Behavior Analysis (ABA) and the most recent version of the ABA Provider Manual.

Louisiana Department of Health Bureau of Health Services Financing

ABA Therapy- Plan of Care

☐ **New** ☐ **Renewal** ☐ **Reconsideration** **Date Services Requested to Start** _____

Recipient Information		Provider Information	
Name		Provider Name	
ID#	DOB	Provider Number	Phone
Address		Address	
Home Phone	Cell Phone	Contact Person e-mail	

Medical Reasons Supporting the Need for ABA Services (Patient Diagnosis)			
Tutor Hours/week	Supervision Hours/week	BCBA Direct Service/week	Total Hours/week

Baseline Level of Behaviors Addressed in the Plan Based on Assessment Results (If necessary, you may use a separate sheet)

Tentative form (v.1) Page 1

Louisiana Department of Health Bureau of Health Services Financing

ABA Therapy- Plan of Care

Recipient Name		Recipient ID#	

Treatment Goals (if necessary, you may use a separate sheet)

Behavior Reduction Plan (if necessary, you may use a separate sheet)

Problem Behavior Topography (SIB, property destruction, tantrums, hitting, etc)

The provider must state the baseline frequency/duration/latency/intensity of all problem behaviors for which a goal is developed

Tentative form (v.1) Page 2

Louisiana Department of Health Bureau of Health Services Financing

ABA Therapy- Plan of Care

Recepient Name		Recepient ID#	
Functional Assessment/Analysis Results (must state a hypothesis of function or provide a finding of function based on a functional ar			
Behavior Plan Goals			
Behavior Improvement Plan (must address the function of the problem behavior and include strengthening a functional alternative be			

Tentative form (v.1) Page 3

Louisiana Department of Health Bureau of Health Services Financing

ABA Therapy- Plan of Care

Parent/Guardian Training and Support Goals			
Recipient Name		Recipient ID#	

Statement of Justification for ABA Therapy Hours Requested (Provide specific information you used to determine the need for ABA therapy at the hours requested)

Specify the predominant location where all services will take place			
Home ☐	Clinic ☐	School ☐	

Specify the hours of service each day during the school year						
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Tentative form (v.1) Page 4

Louisiana Department of Health Bureau of Health Services Financing

ABA Therapy- Plan of Care

Specify the hours of service each day during the summer (if necessary)						
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Signatures		
Parent/guardian	Provider Representative	Physician
Date	Date	Date

Recipient Name		Recipient ID#	