St. Clair County Community Mental Health Authority

ABA Consumer Profile

Date: _____

☐ Private Insurance: _____

Case #:_____ Age:_____ DOB:_____ ☐ Male ☐ Female

Individual:_____ Parent/Guardian Name(s):_____

Address:_____ City:_____

Home Phone #:_____ Cell Phone #: _____

Best time to reach the parent/guardian: _____

CMH Supports Coordinator:_____ Phone #:_____

Email Address:_____

This individual is:

☐ Verbal ☐ Non-Verbal

☐ Uses Sign Language or Visual Supports ☐ Challenging Behavior: ☐ Yes ☐ No (If yes, explain)

Explanation:_____ Describe Behavior:_____

One encounter 97151 must be authorized before this profile is routed.

List in order the preferred ABA providers: _____ Mark N/A if no preference: ☐ N/A

A signed consent for the identified ABA provider(s) must be attached to this profile.

Family prefers the following hours (mark all that apply): ☐ Morning ☐ Midday ☐ After School ☐ Anytime

Family prefers these locations for treatment (mark all that apply): ☐ In Home ☐ Center Based ☐ Both

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Behavioral Assessment Date:_____ Date Completed:_____

☐ VB-MAPP ☐ ABLLS-R ☐ AFLS ☐ Other:_____

Behavioral Plan of Care contains:

☐ Specific targeted behaviors, with measurable, achievable, and realistic goals of achievement to increase functioning skills and independence.

☐ Identification services can/will be delivered at home or in community

☐ Recommendation for service utilization (FBI/CBI)

☐ Incorporation of behavioral observation and direction

☐ Discharge Plan

Authorizations

1 unit = 15 minutes

# of days per week _____

# of hours per day _____

# of units of 97155 U5 (supervision) to be authorized per month _____

# of units of 97155 U5 GT (tele-practice supervision) to be authorized per month _____

# of units of 97156 U5 (family training) to be authorized per month _____

# of units of 97156 U5 GT (tele-practice family training) to be authorized per month _____

Behavioral Follow-Up Assessment

Functional Behavioral Analysis 0362T U5 (requires supervisor approval) _____

Functional Behavioral Analysis 0363T U5 (requires supervisor approval) _____

# of units of 97153 U5 Behavioral Treatment to be authorized per week _____

ABA Services will include behavioral observation/supervision and direction by qualified provider

Addresses risk factors of staff illness, vacation, etc. with specific contingency plan

_____ _____ _____

ABA Supervisor Signature/Credentials Print Name Date

ABA Service Start Date: _____