Applied Behavioral Analysis Treatment Report

Please indicate type(s) of service provided BY OTHERS (select all that apply):

- Medication Management
- Group Therapy
- Occupational Therapy
- Speech Therapy
- Community Program(s)
- Physical Therapy
- Partial/IOP
- Group Home
- Residential
- School/Educational Provider
- Indiv. Psychotherapy
- Family Psychotherapy
- Self Help Group(s)

I am coordinating this patient’s case with other providers as appropriate.

- Psychiatrist
  - Name: __________________________
  - Phone: _________________________
- Psychotherapist
  - Name: __________________________
  - Phone: _________________________
- Primary Care Physician/Pediatrician
  - Name: __________________________
  - Phone: _________________________
- Speech Therapist
  - Name: __________________________
  - Phone: _________________________
- Physical Therapist
  - Name: __________________________
  - Phone: _________________________
- Occupational Therapist
  - Name: __________________________
  - Phone: _________________________
- Other Medical Provider
  - Name: __________________________
  - Phone: _________________________
- Community Services Provider
  - Name: __________________________
  - Phone: _________________________
- State/Regional Agency
  - Name: __________________________
  - Phone: _________________________
- School/Educational Provider
  - Name: __________________________
  - Phone: _________________________

Important Reminders:


Please attach your treatment report to this form and ensure that all required details as described in the ABA Provider Report guidelines are covered.

Graphic representation of the progress made on each goal throughout the whole review period must be included with the review.

Treating Provider’s Signature: ___________________________ Date: ____________

Completed form can be faxed to: 855-241-8895 or mailed to: Horizon Behavioral Health, Attn: ABA Team, PO Box 4274, Cherry Hill, NJ 08034
ABA TREATMENT REQUEST
Please indicate type(s) of service that will be provided by the ABA care team in the next 6 months.

Program Setting: □ Home  □ Clinic  □ Other: __________________
_______________________________________________________________________________________________________________________________

- **Individual** Adaptive Behavior Treatment (Direct 1:1 ABA Therapy)
  - **0364T, 0365T:** direct 1:1 treatment by technician, 30 min. increments.  
    ___ hours per day, ___ days per week
  - **0368T, 0369T:** direct 1:1 treatment by BCBA, 30 min. increments  
    ___ hours per day, ___ days per week
  - **0373T, 0374T:** Exposure Adaptive Treatment requiring 2 or more technicians, for severe maladaptive behaviors, based on an initial 60 mins. with additional 30 min. increments  
    ___ hours per day by technician, ___ days per week

- **Family** adaptive behavior treatment guidance by BCBA
  - **0368T, 0369T:** parent training (one family) with patient present, 30 min. increments  
    ___ hours per day, ___ days per week
  - **0370T:** parent training (one family) without patient present, 30 min. increments  
    ___ hours per day, ___ days per week
  - **0371T:** parent training with multiple family group, without patient present, 30 min. increments  
    ___ hours per day, ___ days per week

- **Group** Adaptive Behavior Treatment
  - **0372T:** Social Skills Group by BCBA, 30 min. increments  
    ___ hours per day, ___ days per week
  - **0366T, 0367T:** Group Adaptive Behavior Treatment by Protocol by technician, 30 min. increments  
    ___ hours per day, ___ days per week

- **Follow-Up Assessment** by BCBA. Administration of tests, interpretation, discussion of findings, recommendations. Assessment of strengths and weaknesses of skill areas across skill domains (e.g., VB-MAPP, ABLLS-R, Functional Behavior Assessment, Functional Analysis).
  - **0360T/0361T:** Observational Behavior Follow-up Assessment, 30 min increments  
    ___ hours per day, ___ days per week
  - **0362T/0363T** Exposure Behavior Follow-up Assessment, 30 minute increments  
    ___ hours per day, ___ days per week

- **Supervision** (BCBA supervision of technicians and parents)
  - **0368T, 0369T:** supervision by BCBA, including supervision of techs, review of treatment data, graphing, updating treatment protocols, preparation of report. Horizon Behavioral Health follows the BACB guideline of 1 hour of supervision for each 5-10 hours of direct treatment by a technician or parent. 30 min. increments.  
    ___ hours per day, ___ days per week

Patient Name: _______________________________  ID#: ______________________
(name and ID are needed to ensure that both pages are for same individual)