Humana Military | TRICARE

Applied Behavior Analysis
Assessment and Treatment Plan

Instructions: Please use the checklist when submitting TRICARE referrals through the self-service portal at **HumanaMilitary.com** to ensure that all necessary clinical information is included and to expedite authorization process. If submitting requests via fax, please complete the appropriate form.

- Name and telephone number of ASD diagnosing provider.
- Initial outcomes evaluation completion (or anticipated completion) date. If evaluation completed, describe symptom severity level (mild, moderate, severe) for each of the following domains:
  - Social interaction
  - Communication
  - Restricted/repetitive behavior
- If the beneficiary currently receives ABA services, please provide the following:
  - Initial start date of ABA services
  - Date of initial assessment and TP
  - Describe current level of care (e.g., sole or tiered provider model and frequency of services including time spent with Assistant Behavior Analysts, BT, ABA Supervisor, etc.) and level of parent/caregiver involvement.
- If the beneficiary currently receiving additional support services, please provide the following information:
  - Total # of hours receiving other services
  - Type of service
  - Frequency
- If the beneficiary currently receives ABA services, describe treatment progress to date.
- Social history (e.g., parent/caregiver relationship status, current living situation, quality and frequency of interactions with family and friends, environmental stressors, hobbies and interests, etc.).
- Educational history (e.g., total # of hours enrolled in school, current grade level, age appropriate grade level, current grades and classroom performance, interactions with teachers and peers, academic strengths and challenges, summary of past and present IEP, etc.).

NOTE: If receiving special education services, a copy of current IEP **must** be submitted with referral and/or service request form.

- Family medical and psychological history (including condition and family member relationship to the beneficiary).
- Name of ABA Supervisor completing current assessment and TP.
- Date and time current assessment and TP completed.

- List all instruments used as part of current assessment.
- Description of direct observations made by ABA supervisor as well as treatment plan and goals for each of the following domains (if applicable):
  - Social domain
  - Communication domain
  - Adaptive skills domain
- Summary of parent/caregiver interview and parent report rating scales (including data if available) as well as parent/caregiver treatment plan and goals.
- Functional behavior assessment/analysis (including description of ASD-related behavior targets, goals, and operational definition(s) - clear, measureable, specific).
- Parent(s)/ caregiver(s) participation is expected, and continued authorization for ABA services is contingent upon their involvement. If parent(s)/caregiver(s) participation is not possible, please provide explanation (i.e., the parent/caregiver is deployed, is physically unable to deliver the ABA services, etc.).
- Projected duration of ABA.
- Barriers which might impede service delivery.
- Statement that the beneficiary is physically and intellectually capable to actively participate in all aspects of the therapeutic program.
- Parent/caregiver signature.

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Please attach support documentation to referral and service requests using the self-service portal at **HumanaMilitary.com**.

Date submitted:

Beneficiary information

Patient name:	☐ M ☐ F	DOB:
Patient ID or SSN:	Active Duty Service Member: ☐ Y ☐ N	
Address:	City/State/Zip:	
DoD benefit #:	Telephone #:	
Referring provider:	Provider telephone #:	

ABA provider

Provider type: ☐ ABA Supervisor ☐ Autism Demonstration Corporate Services Provider (ACSP)

Provider name:	TIN/NPI:
Address:	City/State/Zip:
Telephone #:	Fax #:
ABA supervisor name:	TIN/NPI:

ABA supervisor credentials (mark all that apply):

☐ ABA provider certification: ☐ BCBA ☐ BCBA-D ☐ State cert.

☐ Independently licensed in state that services are provided

☐ BLS/CPR certification

☐ Eight hour supervisory course completed

Other ABA service providers assisting with care:

Provider name:	Title:
☐ Attestation of qualifications by supervisor	

Background information

Medical and treatment history

Current psychiatric and medical conditions (include ASD diagnosis and all co-morbid conditions):

Dx (DSM-5/ ICD-10)	Onset	Description (include symptoms and treatment)

ASD diagnosing provider:	Telephone #:

Initial outcomes evaluation (or anticipated completion) date: If evaluation completed, please indicate symptom severity:

Symptom domain	Mild	Moderate	Severe	Additional comments
Social interaction	☐	☐	☐	
Communication	☐	☐	☐	
Restricted/repetitive behavior	☐	☐	☐	

Current medication(s):

Medication	Psychotropic	Medical	Prescribing MD	PCM	Psychiatrist	Other
	☐	☐		☐	☐	☐
	☐	☐		☐	☐	☐
	☐	☐		☐	☐	☐

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Currently receiving ABA services: ☐ Y ☐ N If yes, initial start date: Date of initial assessment/TP:

Current level of care: ☐ Sole provider model ☐ Tiered provider model Total participation: x per ☐ wk. ☐ mo.

Assistant Behavior Analyst: x per ☐ wk. ☐ mo. Behavior Technician: x per ☐ wk. ☐ mo.

Supervision: x per ☐ wk. ☐ mo. Level of supervision: % of total ABA hrs. per 30 consecutive day period

Parent/caregiver involvement: % of total ABA hrs. per 30 consecutive day period

Additional support services: ☐ Y ☐ N If yes, total # of hours receiving other services: per ☐ wk. ☐ mo. (mark all that apply):

☐ Auditory/sensory integration	☐ Speech therapy
☐ Occupational therapy	☐ Social skills therapy
☐ Nutritional supplements	☐ Play therapy
☐ CBT	☐ Parent-mediated intervention
☐ Physical therapy	☐ Other:

Describe treatment progress:

Level of improvement to date: ☐ Minor ☐ Moderate ☐ Major ☐ No progress

Comments:

Social history

Parent/caregiver relationship status: ☐ Never married ☐ Married ☐ Partnered ☐ Widowed ☐ Divorced ☐ Legally separated

Lives with: ☐ Immediate family ☐ Extended family ☐ Unrelated foster family ☐ Other:

Describe current living situation (including everyone living in household):

Name	Age	Relationship to beneficiary

Describe quality and frequency of interactions with family and friends:

Describe past and present environmental stressors and the impact on patient (deployment, relocation, etc.):

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Describe hobbies/interests/extracurricular activities:

Educational history

Currently enrolled in school: ☐ Y ☐ N If yes, total # of hours: Grade: Age appropriate grade:

If current grade different than age appropriate grade, please explain why (held back, suspension, medical/physical reason):

Grades: ☐ Exceptional ☐ Above average ☐ Average ☐ Below average ☐ Failing

Classroom participation: ☐ Above average ☐ Average ☐ Below average

Current attendance record:	
Academic strengths:	
Academic challenges:	
Describe relationships with peers, teachers, staff, etc.:	

Summarize past and present educational plan, including special education services, as well as any functional behavior assessments, behavior plans, and/or aversive plans used and where the information was obtained (e.g., review of records, interview, etc.).

Past:	
Present:	

NOTE: If receiving special education services, a copy of the current IEP **must** be submitted with the referral and/or service request form.

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Family history

Family history of the following conditions (mark all that apply):

	Comments (include family member relationship to the beneficiary.):
☐ Anxiety	
☐ Depression	
☐ Psychosis	
☐ ADHD	
☐ ASD	
☐ Panic	
☐ OCD	
☐ Substance abuse	
☐ Mania	
☐ Emotional/physical abuse	
☐ Cognitive impairment	
☐ Eating disorder	
☐ Homicidal/suicidal behavior	
☐ Other	

Current assessment and TP

Completed by: Date Time: ☐ am ☐ pm

Instruments used (mark all that apply):

☐ PDDBI

☐ Parent/caregiver interview

☐ Teacher interview

☐ Functional Behavior Analysis

☐ Functional Behavior Assessment

☐ Direct observation: (☐ home ☐ school ☐ community)

☐ Other:

Please describe direct observations made by ABA supervisor:

Social domain observations	Communication domain observations	Adaptive skills domain observations

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Summary of parent/caregiver interview and parent report rating scales (including data if available):

Functional behavioral assessment/analysis

Please describe ASD-related behavior targets, including operational definition(s) - clear, measureable, specific. List only goals for ASD-related behavior targets. Goals which appear academic or educational in nature are not covered as per TRICARE requirements. If goals appear academic or educational, but are intended to be ASD-specific instead, please explain rationale.

Behavior target(s):	
Measurement procedure:	
Baseline:	
Mastery criterion:	
Hypothesized function of behavior:	
ABA intervention(s) to address behavior target:	
Goal(s):	
Objective(s):	
Progress:	

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ABA goals for communication domain:

Goal(s):	
Objective(s):	
Measurement procedure:	
Baseline:	
Mastery criterion:	
ABA intervention(s) to address objective(s):	
Step down care:	
Progress:	

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ABA goals for social domain:

Goal(s):	
Objective(s):	
Measurement procedure:	
Baseline:	
Mastery criterion:	
ABA intervention(s) to address objective(s):	
Step down care:	
Progress:	

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ABA goals for adaptive skills domain:

Goal(s):	
Objective(s):	
Measurement procedure:	
Baseline:	
Mastery criterion:	
ABA intervention(s) to address objective(s):	
Step down care:	
Progress:	

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Parent/caregiver treatment goals:

Goal(s):	
Objective(s):	
Measurement procedure:	
Baseline:	
Mastery criterion:	
ABA intervention(s) to address objective(s):	
Step down care:	
Progress:	

If parent/caregiver training did not occur as scheduled, please provide explanation:

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Additional information

Projected duration of ABA:

Barriers which might impede service delivery:

Statement that the beneficiary is physically and intellectually capable to actively participate in all aspects of the therapeutic program:

Parent/caregiver signature: Date:

Provider signature: Date:

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