Behavioral Health Treatment Reporting Template

IDENTIFYING INFORMATION	
Member Information	
Name:	**Date of Birth:**
Age:	**Primary Diagnosis:**
Health Plan Name:	**Medi-cal ID Number:**
Caregiver's Name:	**Caregiver's phone number:**
Preferred language:	**Alternative phone number:**
Servicing Address:	
PCP Name:	**PCP Phone Number:**
BHT Provider Information	
Company Name:	
Address:	
Provider Contact Phone Number:	**Provider E-mail:**
QAS Provider's Name and Credentials:	**Mid-level/BA level; supervisor's name and credentials:**
Report Information	
Report type: *(FBA or Progress Report #)*	**Current authorization period:**
Date of FBA:	**Date of current report:**
Location(s) of services:	
Timely Access 10-day Timeline Met: *(Yes/No)*	**Date of first available appointment offered** (*FBA or PR1*)**:**
If marked NO provide rationale:	
Percent of session cancelations by caregiver:	**Percent of session cancelations by provider:**

REASON FOR REFERRAL	
Source of referral	**Reason for referral**
☐ L.A. Care Health Plan ☐ Legal Guardian ☐ Other:	

BACKGROUND INFORMATION	
Physical and Mental Health History	
Medical/physical Problems:	**Allergies:**
Gender Specific conditions that could impact treatment :	**History of hospitalizations and recent injures:**
Medications:	**Vision and hearing issues:**
Sleeping difficulties:	**Food selectivity/refusal:**
Swallowing food or liquids issues:	**Additional details:**

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Family Structure	
Primary caregiver:	**Home language:**
Number of people living in the household:	
Space(s) to hold the sessions:	
Level of environmental enrichment:	
Recent changes in the household:	
Department of Child and Family Services (DCFS) Involvement (if applicable)**:**	
Placement in foster/group home (if applicable):	

Member's Availability for Services	Caregiver's Availability for Parent Education
Monday:	Monday:
Tuesday:	Tuesday:
Wednesday:	Wednesday:
Thursday:	Thursday:
Friday:	Friday:
Saturday:	Saturday:
Sunday:	Sunday:

Current or Prior Home or Outpatient Services			
Service Type	**Number of Treatment Hours per Week**	**Dates of Services**	**Provider**

School History and Current School Based Services	
School Name:	**School start and end times:**
Grade:	**School District:**
Special Education Eligibility:	**Date of initial IEP** (if applicable):
Date of the most recent IEP: **Due date for next IEP:**	**Did the BCBA attend the IEP in the last reporting period?**
Did the BCBA coordinate care with the school, in the last reporting period? If so, explain:	**Are the services identified in the IEP being provided?** Identify any barriers, if any:
Plans to address any IEP barriers (if applicable)**:**	**Name and contact information of the service provider(s) (funded by IEP) in the school setting** (if applicable)**:**

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Current Placement
☐ Fully included in a general education classroom ☐ General education class with Resource Specialist Support ☐ Special Day Program Class with inclusion in general education classes ☐ Special Day Program Class with inclusion only during school wide activities ☐ Special Education Center ☐ Non-Public School Placement (e.g., Help Group)
Parental concerns related to client's behaviors and academic performance at school:
If school observation is conducted, teacher concerns related to client's behaviors and academic performance at school:

Special Education Related Services Provided at School (minutes per week)	
☐ Language and Speech (LAS) ☐ Occupational Therapy (OT) ☐ Adaptive Physical Education (APE) ☐ Physical Therapy (PT) ☐ Behavior Intervention Consultation (BIC) ☐ Behavior Intervention Development (BID) ☐ Behavior Intervention Implementation (BII) ☐ Deaf and Hard of Hearing (DHH)	☐ DIS Counseling (Counseling provided by the school psychologist) ☐ Mental Health Counseling ☐ Assistive Technology (AT) ☐ Audiology (AUD) ☐ Orientation and Mobility (O and M) ☐ Orthopedic Impairment Itinerant (OI) ☐ Recreational Therapy (RT) ☐ Visual Impairment Itinerant (VI)

Care Coordination Involving the Caregiver(s), School, State Disability Programs and Others as Applicable

CLINICAL INTERVIEW

Caregiver Concerns and Priorities

Problem Behaviors:	**If reported concerns are not addressed, include rationale:**	**Skill Deficits:**
Previously reported problem Behaviors:		
Newly reported Problem Behaviors:		

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DIRECT ASSESSMENT PROCEDURES/PROGRESS MONITORING RESULTS			
Data Collection			
Dates of Data Collection	**Data Collection Method(s)**	**Location**	**Person(s) collecting data and credentials**

Preference Assessment (PA)		
Date of assessment	**Type of PA**	**List of most preferred items** (Update every 6 months)
	☐ Survey/caregiver interview ☐ Paired choice ☐ Single Stimulus ☐ MSWO ☐ Free Operant Engagement Based	

Skills Assessment Results (e.g., VB-MAPP, Vineland, AFFLS, PEAK, etc.) (Update annually) **Administered Date:**
Results summary or graph:

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TREATMENT PLAN

Skill Acquisition Goals: Identify measurable goals and objectives that are specific, behaviorally defined, developmentally appropriate socially significant and based on clinical observation. Domains such as prerequisite skills, communication, daily living skills, etc.
Use one box per domain

Domain: *(prerequisite skills, communication, daily living skills, etc.)*

Goal (Short-term, intermediate, & long-term)**:**
Generalization criteria (across people, settings, time)**:**
Baseline (based on clinical observation):
Date introduced:
Status: In progress/ Met/ On hold
Teaching plan:

1. **Teaching method:**
2. **Prompting method:**
3. **Program for generalization:**
4. **Data Collection method:**

Present level of performance (Summary)**:**
Environmental barriers that hindered meeting the goal and solution:
Graph (include 12 months' worth of data)**:**

Behavior Reduction Goals

- Complete one table for each problem behavior unless problem behaviors are part of a response class hierarchy

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- If you are addressing multiple problem behaviors, copy and paste Target Problem Behavior table as needed

Target Problem Behavior:	
Operation Definition:	
Baseline level: (collected by clinician, include a baseline graph) If not observed, please include clinical steps that will be taken once services initiate to design a function based treatment plan.	
Function Identification (*Required for all target behaviors being addressed)*: Utilize evidence -based BHT services with demonstrated clinical efficacy to identify the function(s) of behavior **(*FA or conditional probability results - AB & BC graph based on assessor's direct observation*).**	*Insert FA graph or ABC analysis:*
Behavior Reduction goal: (Short-term, intermediate, & long-term)	
Alternative Behavior goal: (Short-term, intermediate, & long-term)	
Generalization criteria (across people, settings, time)**:**	
Initial Treatment Plan: (function based and technological) to address problem behavior(s). Evidence based BHT services with demonstrated clinical efficacy.	*Preventative Antecedent Strategies:* *Teaching Strategies:* *Consequence Strategies:*
Date goal(s) introduced:	
Goal Status: (in progress, met, on hold)	
Present Level of Performance (progress summary):	

Environmental barriers that hindered meeting the goal and solution:	
Graphs (include 12 months' worth of data)**:**	

CAREGIVER/GUARDING TRAINING
Support and participation needed to achieve the goals and objectives for both member and guardian

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Caregiver Training:
Goal (Short-term, intermediate, & long-term)**:** **Generalization criteria** (across people, settings, time)**:** **Baseline** (based on clinical observation): **Date introduced:** **Status:** In progress/ Met/ On hold **Teaching plan:** 1. **Teaching method:** 2. **Prompting method:** 3. **Program for generalization:** 4. **Data Collection method:** **Present level of performance** (summary): **Environmental barriers that hindered meeting the goal and solution:** **Graph** (include 12 months' worth of data)**:**

SUMMARY AND RECOMMENDATIONS	
Summary:	
How many goals were met in the *previous* reporting period	
How many goals have been met in the *current* reporting period	
How many goals will be targeted during the next reporting period	

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Clinical Rationale for Modification of hours (if applicable):

CRISIS PLAN

TRANSITION PLAN

DISCHARGE CRITERIA

Note: Please include the following disclaimer in your reports: The content of this report has been thoroughly discussed with client's parent(s). Parent(s) agree with assessment findings, intervention plans, goals, objectives and recommendation. If parents do not agree with any part of your report indicate which parts and the reason for disagreement.

SIGNATURE(s)

Qualified Autism Service Provider Signature	QASP Credentials	Date