This form is to be completed and submitted by **Board Certified Applied Behavioral Analysis (ABA)** providers to request an initial authorization or re-authorization for ABA Treatment Services

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| **Insurance Eligibility Information**  ***\*Section Required\**** | |
| Medicaid ID: | |
| Member’s Health Share Behavioral Health Plan *(please select one)*: | |
|  | Multnomah County Behavioral Health Plan |
|  | Clackamas County Behavioral Health Plan |
|  | Washington County Behavioral Health Plan |
| *To verify member eligibility, please look in CIM or contact Health Share Customer Service at*  *503‐416‐8090 or 1‐866‐519‐3845* | |
| **Other Primary Insurance Information** *(if applicable)* | |
| Check Type of Members Primary Insurance and Complete Plan Information: | |
|  | Medicare Primary / Medicaid Secondary (Co-Pay Only) |
|  | Third Party Insurance |
| Carrier: | |
| Group/Policy Number: | |
| Effective Date: | |
|  | Not Applicable, member does not have other primary insurance |

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| **Member Information**  ***\*Section Required\**** | | | | |
| First Name: | MI: | | | Last Name: |
| Date of Birth: | | Gender: | | |
| Race/Ethnicity *(optional)*: | |  | | |
| Member Preferred Language: | | | | |
| Interpretation Service Used:  IRCO  Passport to Languages  Linguava  Telelanguage  N/A – No Interpretation Services Needed | | | | |
| Street Address: | | | | |
| City: | State: | | Zip: | |

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| **Member Information**  ***Continued*** | | | |
| Name of Legal Guardian: | Relationship: | | |
| Legal Guardian Preferred Language: | |  | |
| Legal Guardian Contact Phone: | |  | |
| Legal Guardian Email Address: | |  | |
| Name of Caregiver: | | | Same As Legal Guardian |
| Caregiver Preferred Language: | | | |
| Caregiver Contact Phone: | | | |
| Caregiver Email Address: | | | |

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| **Requesting Provider Information**  ***\*Section Required\**** | |
| Referring Provider: | Agency/Role: |
| Phone: | Fax: |
| Email: | |

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| **Contact Person**  *(if different than Referring Provider)* | |
| Contact: | Agency/Role: |
| Phone: | Fax: |
| Email: | |

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| **Care Coordination Information**  ***\*Section Required\**** | |
| **Primary Care Provider** | |
| Name: | |
| Contact Info: | |
| **Mental Health Provider** | |
| Name: | |
| Contact Info: | |
| **Dental Provider** | |
| Name: | |
| Contact Info: | |
| **Developmental Disabilities Provider** | |
| Name: | |
| Contact Info: | |
| **Medication Management Provider** | |
| Name: | |
| Contact Info: | |
| List all current medications and current doses: | |
| N/A – Member does not have a Medication Management Provider | |
| **DHS Child Welfare Worker** | |
| Name: | Contact Info: |
| N/A – Member does not have a DHS Child Welfare Worker | |

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| **Care Coordination Information**  ***Continued*** | | | | | | | | | | | | |
| **Substance Use Disorder Provider** | | | | | | | | | | | | |
| Name: | | | | | | | Contact Info: | | | | | |
| N/A – Member does not have a Substance Use Disorder Provider | | | | | | | | | | | | |
| **School/Early Intervention** | | | | | | | | | | | | |
| Name: | | | | | | | Contact Info: | | | | | |
| School District: | | | | | | | | | | | | |
| Current Education Plan: | | | IEP | | 504 Plan | | | | | ISFP | | |
| **Other Services/Therapies** | | | | | | | | | | | | |
| Check all that apply: | PT | | | SLP | | OT | | | Audiologist | | | Optometrist |
| Other: | | | | | | | N/A – Member does not receive other services | | | | | |
| Name of Provider: | | | | | | | | | | | Type of Provider: | |
| Contact Info: | |  | | | | | | | | | | |
| Name of Provider: | | | | | | | | Type of Provider: | | | | |
| Contact Info: | | | | | | | | | | | | |

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| **Requested Services**  ***\*Section Required\**** | |
| Date of Initial ABA Assessment: | Date of Updated Documentation: |
| Authorization Date Range: | |
| Requested Hours per Week: | |
| Amount Requested per 6 Months\*: $ | |
| ***\*Requested Amount not guaranteed.*** | |

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| **Clinical Documentation Checklist**  ***\*Section Required\**** | |
| **Initial Request** | |
| Please include **all** of the following information for a complete request: | |
|  | Completed ABA Referral Form B: Request for Treatment |
|  | Current ABA Assessment |
|  | Proposed ABA Treatment Plan that includes D/C criteria |
| **Continuation of Services Request** | |
| Please include **all** of the following information for a complete request: | |
|  | Completed ABA Referral Form B: Request for Treatment |
|  | Documentation and tracking of progress and updated standardized assessment tools used to assess progress |
|  | Updated ABA Treatment Plan that includes D/C criteria |

Upon completion of this form, please submit, with **appropriate clinical documentation**, to the member’s assigned Behavioral Health Plan Partner, Attn: Youth Intensive Care Coordination (ICC):

* Clackamas County Behavioral Health**:** Phone: 503-742-5937 | Fax: 503-742-5304
* Multnomah County Behavioral Health**:** Phone: 503-988-4161 | Fax: 503-988-3328 |

Email: [aba.carecoordination@multco.us](mailto:aba.carecoordination@multco.us)

* Washington County Behavioral Health**:** Phone: 503-291-1155 | Fax: 503-846-4560

Email: [ABA@co.washington.or.us](mailto:ABA@co.washington.or.us)

Requests will be reviewed by the Behavioral Health Plan Partner and a determination will be made within **14 calendar days** of a completed request being submitted.

The referent will be notified of approved authorization or a denial of services. If the authorization is approved, a referral to a contracted ABA provider will be provided by the Behavioral Health Plan Partner.