Simply FL BA Authorization Request Form

Fax to: 1-800-370-1116

RECIPIENT INFORMATION			
Recipient Name:	Recipient ID:	DOB:	Age:
Recipient Address:			
Parent/Caregiver Name:		Phone Number:	

PROVIDER INFORMATION		
Provider Group/Agency:	Lead Analyst:	Agency Contact:
Group NPI:	Phone #:	Clinical Contact Email:
Group TIN:	Fax #:	Network Capacity: ☐ In Network ☐ Out of Network
Provider Group Address:		

DIAGNOSTIC INFORMATION	
Primary Diagnosis:	
Diagnosing Provider:	Date of Diagnosis:
Have medical evaluations or treatments been implemented to rule out or address possible organic etiologies for the behavior(s) of concern? (If yes, please attach documentation) ☐ Yes ☐ No ☐ N/A	

SERVICES REQUESTED	
Requested Start Date:	
Type of Request (Select one): ☐ **Initial Assessment** (must include CDE and BA referral) ☐ Includes BA referral signed by a physician or child psychologist dated within the past year ☐ Includes Comprehensive Diagnostic Assessment (CDE) with a diagnosis ☐ **Assessment/Initial Treatment** (must include CDE, BA referral, BASC and Vineland scoring and report, Behavior Assessment, and Behavior Plan) ☐ **Reassessment/Concurrent** (must include CDE, BA referral, BASC and Vineland scoring and report, Behavior Assessment, and Behavior Plan)	
Location of Services: (Select all that apply.) ☐ Home ☐ School (requires clinical rationale) ☐ Center/Clinic ☐ Other _______	**Level of Care:** ☐ Focused ☐ Comprehensive

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NOTE: *40 hour/week maximum *Reassessment request should be included with the treatment request
*Please see fee schedule for comprehensive code descriptions

Code	Service Description	Modifier	Hours/Week	Total # Units
97151	Behavior Identification-assessment (Maximum 24 units)			
97151	Behavior reassessment (Maximum 18 units)	TS		
97152	Behavior Identification-supporting assessment (Maximum 8 units) **** Clinical Rationale Required***			
0362T	2:1 assessment with Lead Analyst **** Clinical Rationale Required***			
97155	Behavior treatment with protocol modification by a Lead Analyst **** 10-20% of direct care by RBT***			
97155	Behavior treatment with protocol modification by BCaBA	HN		
97153	Behavior treatment by protocol by RBT, BcaBA, or Lead Analyst			
0373T	2:1 treatment with Lead Analyst **** Clinical Rationale Required***			
97156	Family training by Lead Analyst			
97156	Family training by BcaBA	HN		
97156	Family training by telemedicine (Maximum 2 hours/week)	GT		
97154	Group skills training, max. 6 clients			
97158	Group skills training, max. 6 clients by Lead Analyst or BcaBA			

CLINICAL INFORMATION

PARENT/CAREGIVER INVOLVEMENT	SCHOOL INFORMATION
Did the primary caregiver participate in at least 50% of the scheduled parent training sessions? ☐ Yes ☐ No If not, is there a plan to address barriers and promote generalization? ☐ Yes ☐ No	Does the recipient attend school? ☐ Full time ☐ Half day ☐ Other ___________ Does the recipient have an IEP/504 plan? (If yes, please attach documents) ☐ Yes ☐ No

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ASSESSMENTS	
Vineland-3 Comprehensive Parent Interview Form (for all recipients) including Maladaptive Behavior Domain (for recipients ages 3 years and older) Date of most recent ABC score: Most recent ABC score; Date of previous ABC score: Previous ABC score:	Behavior Assessment System for Children, 3rd Edition, Parenting Relationship Questionnaire (BASC-3 PRQ), (for all recipients ages 2 years through 18 years) Date of most recent BASC-3 score: Attachment: Discipline Practices: Involvement: Parenting Confidence: Relational Frustration:
MALADAPTIVE BEHAVIOR	**PROGRESS**
Select all applicable maladaptive behavior(s): ☐ High risk to self ☐ Aggression to others ☐ Property destruction or disruption Was medical care required as a result of the behavior? ☐ Yes ☐ No Was law enforcement required as a result of the behavior? ☐ Yes ☐ No	Percentage of goals met: Ex. 15 out of 20 goals met = 75% Behavior reduction: Skill acquisition: Parent Training:

BEHAVIORAL HEALTH AND OTHER SERVICES					
Date recipient began receiving BA services:					
What other services does the recipient currently receive or has received in the past 12 months?					
Service	**Current**	**Previous**	**Services**	**Current**	**Previous**
Crisis Intervention	☐	☐	School Based Services	☐	☐
Residential Treatment	☐	☐	Occupational Therapy	☐	☐
Intensive Outpatient Treatment	☐	☐	Speech Therapy	☐	☐
Medication Management	☐	☐	Physical Therapy	☐	☐

PROVIDER SIGNATURE	
Lead Analyst Signature	Date