Applied Behavior Analysis (ABA) Services
Intent to Initiate Treatment

This form notifies DPHHS of the intent to initiate Applied Behavior Analysis (ABA) services for a member with a provisional qualifying diagnosis as delineated in the Eligibility Criteria and who meets Functional Impairment Criteria. DPHHS is unable to reimburse a provider for services rendered unless this form is completely and accurately filled out and submitted. Please send all required information and documentation to via the secure Montana File Transfer Service at https://transfer.mt.gov to DDPServiceRequest@mt.gov.

Provisional Qualifying Diagnosis

- ☐ Autism Spectrum Disorder*
- ☐ Serious Emotional Disturbance*
- ☐ DD Eligible**

*Any physician, licensed mental health professional, or qualified healthcare professional may refer a member for the initiation of ABA services under these provisional qualifying diagnoses. However, to be eligible for re-authorization of ABA services, the provisional qualifying diagnosis must have been established a qualified healthcare professional with expertise in the diagnostic area.

**Any member being served with a qualifying diagnosis of Developmental Disability must have been deemed eligible for the receipt of state-sponsored developmental disabilities services.

Date of Submission _____

Member Name _____

Date of Birth _____

Medicaid Card ID _____

Parent or Guardian/Caregiver Name _____

Parent or Guardian/Caregiver Contact Information _____

Provider Name _____

Provider Contact Information _____

Provider NPI _____

Provider License Number _____

Start Date for Services _____

Enter the first date of service, which may pre-date the Date of Submission.

By signing below, the service provider confirms in writing all of the following:

- ☐ A physician, licensed mental health professional, or other qualified healthcare professional* has documented that the member meets Functional Impairment Criteria and that the service is medically necessary to ameliorate the symptoms of the stated provisional qualifying diagnosis.
- ☐ The licensed Board Certified Behavior Analyst (BCBA) who will be delivering services has confirmed in writing the medical necessity of the service and the expectation that the member's presenting deficits will improve to a clinically meaningful extent.
- ☐ The parent or guardian of the member receiving the services has confirmed in writing a commitment to participate in the goals of the treatment plan.
- ☐ The licensed BCBA who will be delivering the services agrees to provide all Service Requirements as delineated in the *ABA Services Manual* and within nationally accepted standards of practice.
- ☐ The licensed BCBA who will be delivering the services has agreed to deliver initial services, not to exceed a maximum of 180 calendar days or 1,260 units of service, whichever elapses first.
- ☐ The licensed BCBA who will be delivering the services understands and agrees that additional days or units of service beyond those noted above will require prior authorization.

Signature _____ **Date** _____

Required Supplemental Documentation

- ☐ The physician, licensed mental health professional, or other qualified healthcare professional* making the referral **must complete a prescription or equivalent document, which lists the provisional qualifying diagnosis and states that the referral is for ABA services**. This document must accompany this form for it to be considered complete.

For Department Use Only

Received Date _____ Staff Initials _____