eQ Health SOLUTIONS	Behavioral Analysis Services PRIOR AUTHORIZATION REQUEST CLINICAL INFORMATION FORM	Return to: Ph:855-444-3747 Fax:855-440-3747

GENERAL INFORMATION

Recipient Number	Last Name	First Name	Date of Birth

Type of Request: ☐ New (prior to service) ☐ Retrospective (after service due to retroactive eligibility)
☐ Modification of existing eQHealth PA ☐ Continuation of services

If this is a Modification or Continuation of services, please include the initial eQHealth authorization number:

PA#

Answer these questions for ALL review types

Has the child received behavior analysis services from a different organization in the past 0-6 months?	☐ **Yes**	☐ **No** ☐ **Unknown**
Has the child has been diagnosed with a condition for which behavior analysis services are recognized as therapeutically appropriate?	☐ **Yes**	☐ **No**
Is the child medically stable and can remain in a home environment without the need for 24-hour monitoring?	☐ **Yes**	☐ **No**
Is the primary caregiver willing and able to support the child's therapy?	☐ **Yes**	☐ **No**

Answer these questions for New review types

Has the child received behavior analysis services from your organization in the past 0-6 months?	☐ **Yes**	☐ **No**

How long was the child on a wait list prior to scheduling the assessment? Select one response below

- ☐ **The child was not on a wait list**
- ☐ **The wait was one month or less**
- ☐ **The wait was between one and three months**
- ☐ **The wait was between three and six months**
- ☐ **The wait was longer than six months**

Answer these questions for Continuation or Modification review types

FROM Question 1 -4 Select the *primary* maladaptive behavior(s) to address during this period.
For YES responses select all applicable behaviors from the list :

1. High risk to self (caused or presented imminent risk of harm in the last 6 months)? *If YES Select all below that apply:*	☐ **Yes**	☐ **No**
☐ **Elopement (leaving house/clinic/safe area or supervision)**		
☐ **Suicide attempts**		
☐ **Suicidal talk or illustration - threats to cause harm to self (with ability to follow-through)**		
☐ **Cutting self (covert, non-suicidal)**		
☐ **Illegal drug use**		
☐ **Prostitution**		
☐ **Sexting (sending texts with nude or suggestive pictures)**		
☐ **Climbing – presenting risk of fall**		

☐ **Property misuse presenting a danger to self (e.g., electrical shock, cuts)** ☐ **Bruxism (teeth grinding)** ☐ **Trichotillomania (hair removal)** ☐ **Mouthing unsafe objects** ☐ **Pica (consuming inedibles, toxic substances)** ☐ **Rectal digging, feces smearing** ☐ **Feces eating** ☐ **Trichophagia (hair eating)** ☐ **Polyphagia (excessive eating)** ☐ **Polydipsia (excessive drinking)** ☐ **Excessive vomiting (rumination)** ☐ **Bulimia** ☐ **Anorexia** ☐ **Food refusal (over-selectivity that impacts nutrition and results in weight loss** ☐ **Failure to thrive** ☐ **Aerophagia (air swallowing)** ☐ **Biting self** ☐ **Nail biting, picking, removal** ☐ **Skin picking, pinching, scratching** ☐ **Head slapping/hitting (e.g., hand/knee/object to self)** ☐ **Head banging on hard surfaces** ☐ **Head banging on soft surfaces** ☐ **Eye poking (self)** ☐ **Refusal to comply with medical or dental care/evaluations** ☐ **Refusal to comply with hygiene care/routines that impacts health and/or social acceptance** ☐ **Other (please describe in the space provided below)**		
2. Aggression to others – actual contacts and attempts (“near misses”) – intensity (force), frequency and/or duration that caused or presented imminent risk of severe injury in the last 6 months? *If YES Select all below*	☐ **Yes**	☐ **No**

that apply: ☐ **Head butt, hit, slap, pinch, scratch, hair pull, or bite adults** ☐ **Head butt, hit, slap, pinch, scratch, hair pull, or bite children or other vulnerable persons (aged, disabled)** ☐ **Striking with or throwing objects** ☐ **Spitting, licking, wiping saliva** ☐ **Contacting genitalia, breast, butt – forced kissing, licking** ☐ **Other (please describe in the space provided below)**		
3. Property destruction or disruption (caused or presented imminent risk of high value property loss or repair in the last 6 months)? *If YES Select all below that apply:* ☐ **Property destruction** ☐ **Throwing objects** ☐ **Pushing objects off tables (e.g., during instruction)** ☐ **Feces smearing** ☐ **Spitting, licking** ☐ **Other (please describe in the space provided below)**	☐ **Yes**	☐ **No**
4. Severe atypical behaviors in intensity (force), frequency and/or duration that occurred in the last 6 months? *If YES Select all below that apply:* ☐ **Fire setting or play with matches, lighters or other inflammables** ☐ **Verbal or illustrated threats to cause harm to others** ☐ **Coercion of other children or other vulnerable persons (aged, disabled)** ☐ **Property theft, extortion** ☐ **Lying** ☐ **Vandalism** ☐ **Truancy** ☐ **Verbal threats of sexual nature** ☐ **Saying inappropriate words (e.g., swear, racial slur, LGBTQ slur, name calling, sexual terms)** ☐ **Undressing in public, exposing own genitalia, or masturbation in public** ☐ **Voyeurism (watching people inappropriately)** ☐ **Tantrums - not age typical for a 2-3 year old child** ☐ **Verbal refusal** ☐ **Physical refusal to move (e.g., laying on ground, squatting)** ☐ **Screaming, yelling, crying**	☐ **Yes**	☐ **No**

☐ **Bolting (running away from instruction or activity, but remaining in safe area)** ☐ **Saliva play or smearing** ☐ **Enuresis** ☐ **Encopresis** ☐ **Feces play or smearing** ☐ **Perseverative behaviors** ☐ **Ritualistic, intense preoccupation with, obsessive repetition of actions (e.g., hand washing, checking lights off, door locked)** ☐ **Repeating task to obtain perfection** ☐ **Movement (motor) tics** ☐ **Movement stereotypy (e.g., hand flapping, spinning objects, spinning self, rocking)** ☐ **Non-typical toy play** ☐ **Lining up objects** ☐ **Counting** ☐ **Hoarding objects** ☐ **Difficulty with expressive language (communicating what the child wants/needs or does not want/need)** ☐ **Difficulty with receptive language** ☐ **Difficulty with initiating, sustaining, and/or responding to communicative and social interactions with others** ☐ **Poor understanding or use of non-verbal communication** ☐ **Vocal tics** ☐ **Vocal or auditory stereotypy (e.g., delayed echolalia, singing, noises)** ☐ **Echolalia** ☐ **Selective mutism** ☐ **Ritualistic, intense preoccupation with topics (verbal)** ☐ **Gazing stereotypy** ☐ **Hyper-reactivity to sensory input** ☐ **Hypo-reactivity to sensory input** ☐ **Hyperactivity** ☐ **Impulsivity** ☐ **Inattention** ☐ **Severe insomnia, excessive sleeping during day (sleep disorder)** ☐ **Other (please describe in the space below)**		
Was medical evaluation or care required as a result of the behavior? If yes, please describe below .	☐ **Yes**	☐ **No**
Was another child or vulnerable person involved, assaulted or injured? If yes, please describe below	☐ **Yes**	☐ **No**

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Was a law enforcement officer involved as a result of the behavior? If yes, please describe below	☐ **Yes**	☐ **No**
Is the behavior expected to increase in intensity, frequency or duration resulting in greater risk? If yes, please describe below	☐ **Yes**	☐ **No**

If property was damaged or lost, what was the estimated value?

- ☐ **More than $1000**
- ☐ **$500-$1000**
- ☐ **$250-$500**
- ☐ **$100-250**
- ☐ **Less than $100**

What treatment model will be provided? (as shown in BACB guidelines)

- ☐ **Focused**
- ☐ **Comprehensive**

Where will treatment be provided?

- ☐ **Home**
- ☐ **School & Community**
- ☐ **Clinic/Outpatient**
- ☐ **Residential**
- ☐ **Hospital/Inpatient**

Have restrictive or crisis management procedures been implemented in the last 6 months? Select all that apply and provide the average time per behavioral event in the space provided

- ☐ **Seclusion** _____
- ☐ **Mechanical restraint** _____
- ☐ **Manual restraint** _____
- ☐ **Restricting movement or access to reinforcers or normal environment with devices, barriers, furniture, locks** _____
- ☐ **Behavior protective equipment (e.g., helmet for headbanging, gloves for hand-mouthing, padded clothing, belt, strap, harness, splint)**_____
- ☐ **Dietary manipulations** _____

Have less intrusive or less intensive behavior interventions been provided or considered?	☐ **Yes**	☐ **No**
Have medical evaluations or treatment been implemented to rule out or address possible organic etiologies for the behavior(s) of concern? **Provide documentation if yes**	☐ **Yes**	☐ **No** ☐ **N/A**
Have other therapy services such as occupational therapy, physical therapy, or speech therapy been provided or considered?	☐ **Yes**	☐ **No**

What other behavioral health services is the child currently receiving? Select all that apply

- ☐ **None**

☐ **Crisis Intervention (e.g., psychiatric hospitalization, Baker Act)** ☐ **Residential Treatment** ☐ **Day Treatment** ☐ **Intensive Outpatient Therapy** ☐ **Medication Management** ☐ **Cognitive Behavioral Therapies** ☐ **School based services** ☐ **Other (Specify)**		
Is it your professional opinion that no equally effective alternative is available for reducing interfering behaviors, increasing prosocial behaviors, or maintaining desired behaviors?	☐ **Yes**	☐ **No**
During the last treatment period were any sessions or parent training/coaching sessions missed? If yes, provide the number of missed sessions in the textbox.	☐ **Yes**	☐ **No**
	☐ **Number of Missed Sessions**	
What was the primary or most often cause for the missed session? ☐ **Staffing Issue** ☐ **Child/Parent/Legal Guardian schedule** ☐ **Child Illness** ☐ **Parent/Legal Guardian illness** ☐ **Staff Illness** ☐ **Caregiver refusal** ☐ **Elopement** ☐ **Other Specify**		
Does the behavior support plan include any form of punishment interventions?	☐ **Yes**	☐ **No**
A. If yes, have all reinforced based reduction tactics have been tried and failed?	☐ **Yes**	☐ **No**
Does the behavior support plan include any form of restrictive or crisis management procedure?	☐ **Yes**	☐ **No**
Specify procedures included in the behavior support plan. Select all that apply ☐ **Time Out (exclusionary)** ☐ **Contingent observation (non-exclusionary)** ☐ **Response Blocking** ☐ **Response cost** ☐ **Overcorrection (e.g., positive practice, restitution)** ☐ **Contingent exercise** ☐ **Contingent aversive (i.e., noxious, painful) stimulus presentation (e.g. bitter substance for mouthing, water mist)** ☐ **Dietary manipulations** ☐ **Satiation or deprivation procedures** ☐ **Systematic desensitization (gradual exposure – in vivo, flooding)** ☐ **Other Specify**		
Did the caregiver provide a written approval for punishment, restrictive or crisis management procedures interventions?	☐ **Yes**	☐ **No**
Does the behavior support plan include custodial or respite care?	☐ **Yes**	☐ **No**

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REMINDER: a signed behavior support plan must be provided with the review request that describes the following:

- **Outlines specific and measurable goals**
- **How the direct treatment hours will be delivered at a sufficient intensity to achieve treatment plan goals**
- **Evaluation plan to measure the impact of the treatment on the child's behavior/skills**
- **Measure of functional improvement changes that have proven to be durable past the treatment session, confirmed through data and documented in charts and graphs**

Printed Name/Credentials	**Signature**	**Date**

Form date April 2018