Health SOLUTIONS

BEHAVIOR ANALYSIS (BA) TREATMENT PLAN FORM

☐ **Admission**	☐ **Continued Stay**	**Date Services Requested to Start _____**

Recipient Information		Provider Information	
Name		Provider Name	
ID#	DOB	Provider Medicaid Number	Phone
Address		Address	
Home Phone	Cell Phone	Contact Person e-mail	

Medical Reasons Supporting the Need for BA Services

(Recipient Diagnosis)

RBT Technician Hours/week	BCaBA Hours/week	BCBA or Licensed Practitioner Direct Service/week	Total Hours/week

Baseline Level of Behaviors Addressed in the Plan Based on Assessment Results

(If necessary, you may use a separate sheet)

Health SOLUTIONS

BEHAVIOR ANALYSIS (BA) TREATMENT PLAN FORM

Recipient Name		Recipient ID#	

Treatment Goals (if necessary, you may use a separate sheet)

Health SOLUTIONS

BEHAVIOR ANALYSIS (BA) TREATMENT PLAN FORM

Recipient Name		Recipient ID#	

Behavior Reduction Plan (if necessary, you may use a separate sheet)

Problem Behavior Topography (SIB, property destruction, tantrums, hitting, etc)

The provider must state the baseline frequency/duration/latency/intensity of all problem behaviors for which a goal is developed

Health SOLUTIONS

BEHAVIOR ANALYSIS (BA) TREATMENT PLAN FORM

Recipient Name		Recipient ID#	

Functional Assessment/Analysis Results (must state a hypothesis of function or provide a finding of function based on a functional analysis)

Behavior Plan Goals

Behavior Improvement Plan (must address the function of the problem behavior and include strengthening a functional alternative behavior)

Health SOLUTIONS

BEHAVIOR ANALYSIS (BA) TREATMENT PLAN FORM

Recipient Name		Recipient ID#	

Parent/Legal Guardian Training and Support Goals

Statement of Justification for BA Services Hours Requested

(Provide specific information you used to determine the need for BA services at the hours requested)

Specify the predominant location where all services will take place

Home ☐	Clinic ☐	School ☐	Other _____

Specify the hours of service each day during the school year

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Specify the hours of service each day during the summer (if necessary)

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Signatures

Parent/Legal Guardian	Provider Representative	Physician (Optional – Not Required)