Marc Community Resources, Inc.
Applied Behavior Analysis (ABA) Services Request

What is ABA?

Applied Behavior Analysis (ABA) is a scientific discipline that utilizes behavioral principles to help individuals make meaningful and socially significant behavior changes. Marc Community Resources' ABA program utilizes Board Certified Behavior Analysts (BCBA) to conduct functional behavior assessments, design behavior support plans and train support staff and family members on how to implement written strategies. The goal of Marc's ABA program is to teach individuals how to access their environment more effectively, thereby reducing the need to engage in aberrant target behaviors. Marc's behavior support plans utilize positive reinforcement strategies, as well as a variety of other proactive measures to motivate individuals during the behavior change process. On-going support, training and consultation services will be available to help service providers and family maintain treatment gains.

Please include the following documents with the ABA Services Request:

1. Consent to Release Information
2. ISP that includes:
    a. **The need for ABA services**
    b. **BHP signature**
3. Part E Assessment
    a. **BHP signature**
4. At Risk Crisis Plan
5. Last Psychiatric Evaluation
6. Med Flow Sheet
7. 1 month of Psychiatric Progress Notes
8. 2 weeks of Case Management Progress Notes
9. Copy of Guardianship paperwork (if applicable)
10. Copy of COT paperwork (if applicable)
11. Previous FBA or Behavior Support Plan (if applicable)

Please email to submit the form and documents to: ABA.referrals@marccr.com

Date of Referral: ________________

Section 1: Basic Demographic and Clinical Information

Individual Name:	**DOB:**	**Age:**	**CIS#:** **AHCCCS#:**

Case Manager Name:	**CM Phone #:** **CM Email:**

PNO/Clinic Name & Address:	**Clinic Phone #:**	**Clinic Fax #:**
	Clinical Coordinator Name: **Clinical Coordinator Email:**	

Current Level of Care (LOC): ☐ **Connective** ☐ **Supportive** ☐ **ACT** ☐ **MACT**

Rate the individual's level of engagement in treatment

☐ **Not Engaged** ☐ **Somewhat Engaged** ☐ **Very Engaged** ☐ **Highly Engaged**

Guardian Name & relationship to client:	**Guardian Phone #:** **Guardian Email:**

Please describe the guardian's or primary caregiver's level of involvement in treatment:

☐ **Not Involved** ☐ **Somewhat Involved** ☐ **Very Involved** ☐ **Highly Involved**

**Please share any additional information you have regarding guardian or primary caregiver participation in this individual's treatment:*

If the individual is enrolled in services with DDD, please provide the following:

DDD Support Coordinator Name:	**DDD Coordinator Phone #:** **DDD Coordinator Email:**

Please describe DDD Involvement with services for this individual if applicable:

Does client have a permanent placement? ☐**Yes** ☐**No** **If yes, please list provider name, type/ level of care &* ***Address** of current residence:*	**Is the client currently inpatient?** ☐**Yes** ☐**No** **If yes, please provide location:*

History of Placements (*Please list **ALL** placements the individual has been in over the **past year***)

Name of Placement(s):	Duration of Stay:	Reason for Transfer:

Is client Title19/TXIX? ☐**Yes** ☐**No** *Client must be Title 19 in order to be eligible for services

Please Check one: ☐**SMI** ☐**GMH**

COT Type (check all that apply): ☐**DTO** ☐**DTS** ☐**PAD** ☐**GD**

Start Date: ____________________ **End Date:**_________________

Legal History (felony, sex offender, etc.):

Please provide the most recent diagnosis codes from the latest psychiatric note:

Psychiatrist Name and Clinic:	**Psych. Phone #:** **Psych. Email:**
PCP/General Physician Name and Practice:	**PCP Phone #:** **PCP Email:**

Is there currently a Behavior Specialist working with the individual? ☐ **Yes** ☐ **No**

If Yes, was there an FBA completed? ☐**Yes** ☐ **No**

If Yes, provide name of agency or service provider:

____

Reason for Referral:

Section 2: Target Behaviors

Please list the individual's behaviors and specify the estimated number of times they have been engaging in these behaviors during a given period of time (*per day, per week, or per month*).	**Frequency**	
Type of Behavior & Description:	average # of incidents	per time period **(check one)**
Behavior 1: ______________________		*Day / Week / Month* ☐ ☐ ☐
Behavior 2: ______________________		*Day / Week / Month* ☐ ☐ ☐
Behavior 3: ______________________		*Day / Week / Month* ☐ ☐ ☐
Behavior 4: ______________________		*Day / Week / Month* ☐ ☐ ☐
Behavior 5: ______________________		*Day / Week / Month* ☐ ☐ ☐
Behavior 6: ______________________		*Day / Week / Month* ☐ ☐ ☐
Behavior 7: ______________________		*Day / Week / Month* ☐ ☐ ☐

Comments (triggers, severity of behavior(s), etc.):

Section 3: Supportive Components for ABA Services

1.	Is the individual in a housing environment with direct support staff? **If **no** skip to question #5. If **yes** proceed to the next question.*	☐ **Yes** ☐ **No**
2.	If yes to the above question, are the direct support staff (not just on site) available 24 hours?	☐ **Yes** ☐ **No**
3.	Is the staff to client ratio where the client lives no more than 1:4?	☐ **Yes** ☐ **No**
4.	If yes, is this a temporary housing arrangement (30 day or less TLP)?	☐ **Yes** ☐ **No**
5.	Does the individual live in home with family or primary caregiver?	☐ **Yes** ☐ **No**
6.	If yes, are the family members or primary caregiver willing and able to support the behavior plan?	☐ **Yes** ☐ **No**
7.	If they are willing and able to assist with the plan, will they agree to having additional staff in their home?	☐ **Yes** ☐ **No**

Section 4: Psychiatric and Medical Hospitalizations

Please list ALL hospitalizations in the past year:			
Hospital Name:	**Date hospitalized:**	**Duration of stay:**	**Reason for hospitalization:**

Section 4: Psychiatric and Medical Hospitalizations (cont.)

Please list ALL hospitalizations in the past year			
Hospital Name:	**Date hospitalized:**	**Duration of stay:**	**Reason for hospitalization:**
Comments			

Case Manager Name (Print)

Case Manager Signature

Date

Clinical Coordinator Name (Print)

Clinical Coordinator Signature

Date