# Applied Behavioral Analysis (ABA) Day Program Capacity Attestation

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| **Start Up**  **Expansion** |
| Provider agency name: | Provider agency domain #: | | | | |
| Provider agency address(es): | County/counties serving: | | | | |
| Key ABA contact person: | Phone number and email: | | | | |
| **Background** | | | | | |
| The ABA Capacity Attestation must be completed by an agency in collaboration with HCA upon the initiation and any expansion of ABA within their area. | | | | | |
| **ABA Key Elements** | | **Yes** | **No** | **Comments** | | |
| Provider agency holds current Behavioral Health Agency License, issued by the Division of Behavioral Health and Recovery (DBHR) | |  |  |  | | |
| Provider agency is enrolled with Apple Health (Medicaid) | |  |  |  | | |
| Provider agency has credentialed staff to provide services according to the model guidelines; please include a staffing list | |  |  |  | | |
| * Therapy assistants at a 1:1 ratio for 3 hours a day per child | |  |  |  | | |
| * Lead Behavior Therapist providing direct supervision of each child’s program for 5% of the time the child is in the program and, must remain on site during all program hours | |  |  |  | | |
| * Speech therapy for the initial assessment, planning and data programming as well as direct, individualized treatment with an SLP weekly at a minimum | |  |  |  | | |
| * Parent Training will consist of direct individualized training with an LBAT weekly at a minimum | |  |  |  | | |
| * Functional activities for daily living at a rate of 4 sessions per week per child | |  |  |  | | |
| * Coordination of Care activities at a rate of 1 session per week per family as needed during the program based on individual child needs | |  |  |  | | |
| * Discharge/Transition Services must be provided | |  |  |  | | |

**Anticipated Medicaid capacity number**:

**Anticipated schedule** (sessions per day, days per week, hours, enrollment limitations):

*I have received and reviewed the day program guidelines, understand them and agree to comply with said guidelines.*

Provider agency: Print name  Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: //

**Please return this form via email to** [**ABA@hca.wa.gov**](mailto:ABA@hca.wa.gov) **or fax to 360-725-1328.**

**HCA Approval**

Print name  Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: //