**Applied Behavioral Analysis (ABA)   
Day Program Capacity Attestation**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Provider Agency Name:** |  | | **Provider Agency Domain #** | | | | | |  | |
| **Provider agency address(s)** |  | | | | | | | | | |
| **Startup/Expansion** |  | | | **County/Counties Serving:** | | | |  | | |
| 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 is enrolled with Apple Health (Medicaid) | | | | |  |  |  | | | |
| Provider agency has credentialed staff to provide services according to the model guidelines; please include staffing list | | | | |  |  |  | | | |
| Therapy assistants at 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 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: |
| HCA approval Print name: | | Signature: | | | | | | | | Date: |

**Send completed form to: Questions?** Toll-Free 1-800-562-3022 ext. 16137

Provider Enrollment

P.O. Box 45562

Olympia, WA 98504-5562

**Fax:** 360-725-2144

Attn: Provider Enrollment