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

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| --- | --- | --- | --- |
| **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 agencyPrint name:       | Signature: | Date:       |
| HCA approvalPrint 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