Applied Behavioral Analysis (ABA) Day Program Capacity Attestation

Washington State Health Care Authority

The *ABA Day Program Capacity Attestation* must be completed by an agency in collaboration with HCA upon the initiation and any expansion of the ABA day program. Please review the qualifications and requirements in the **ABA billing guide** before completing this form. To send completed form or to ask any questions, email **aba@hca.wa.gov**.

1 Provider agency information

Provider agency name

Provider agency domain number

Provider agency contact name

Provider agency email

Provider agency address(s)

Startup or Expansion?

County/Counties serving

2 ABA key elements

Please review the key elements below. Check "yes" or "no" regarding whether the day program will meet each key element, then describe how the program plans to meet the key element.

1. Provider agency is enrolled with Apple Health (Medicaid). ☐ Yes ☐ No

Comments:

2. Provider agency has credentialed staff (SLPs, LBAs, LABAs, CBTs, etc.) to provide services according to the model guidelines; **please attach a staffing list**. ☐ Yes ☐ No

Comments:

3. Therapy assistants at 1:1 ratio for 3 hours a day per client. ☐ Yes ☐ No

Comments:

4. Lead Behavior Analysis Therapist (LBAT) providing direct supervision of each client's program for a minimum of 5% of the time the child is in the program and must remain on site during all program hours. ☐ Yes ☐ No

Comments:

5. Speech therapy for the initial assessment, planning and data programming as well as direct, individualized treatment with an SLP weekly at a minimum. ☐ Yes ☐ No

Comments:

6. Caregiver/family training will consist of direct individualized training with an LBAT weekly at minimum. ☐ Yes ☐ No

Comments:

7. Individualized, comprehensive treatment plans with 4-5 sessions per week for 48 days. ☐ Yes ☐ No

Comments:

8. Coordination of Care activities provided as needed during the program based on individual client needs, but at a minimum of 3 times throughout the 48 day program. ☐ Yes ☐ No

Comments:

9. Discharge/Transition services must be provided. ☐ Yes ☐ No

Comments: _____

10. The day treatment program must have the capacity to individualize the need for 1:1 versus dyadic or group instruction as needed. ☐ Yes ☐ No

Comments: _____

11. Please attach pictures of the clinic and/or a floor plan with a description of how the space will be utilized. ☐ Yes ☐ No

Comments: _____

_____

Anticipated Medicaid Capacity number

_____

Anticipated schedule (sessions/day, days/week, hours, enrollment limitations)

3 Signature

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

Provider agency signature	Provider agency name	Date
HCA approval signature	HCA approval name	Date