Functional Behavior Assessment/Progress Report

I. IDENTIFYING INFORMATION

Patient's Last/First Name:					
Patient's Date of Birth:					
Patient's age:	FBA	PR 1	PR 2	PR 3	PR 4
Patient's Diagnosis:					
Legal Guardian's Name:					
Legal Guardian's Phone:					
Home language:					
Service Address:					
Health Plan Name:	**L.A. Care Health Plan**				
Medical ID#:					
PCP Name:	FBA	PR 1	PR 2	PR 3	PR 4
PCP's phone number:	FBA	PR 1	PR 2	PR 3	PR 4
10 day timeline is met: (Y/N)	FBA	PR 1	PR 2	PR 3	PR 4
Date of first available appointment offered:					
Date of Report:	FBA	PR 1	PR 2	PR 3	PR 4
The Business Name of the Provider:	FBA	PR 1	PR 2	PR 3	PR 4
QAS Provider's Name and Credentials:	FBA	PR 1	PR 2	PR 3	PR 4
Mid-level/BA level; supervisor's name and credentials:					
Provider Contact Phone Number:	FBA	PR 1	PR 2	PR 3	PR 4
Percent of Session Cancelations by Parent:	FBA	PR 1	PR 2	PR 3	PR 4
Percent of Session Cancelations by Provider:	FBA	PR 1	PR 2	PR 3	PR 4

II. REASON FOR REFERRAL

Source of referral	Reason for referral
☐ L.A. Care Health Plan ☐ Legal Guardian ☐ Other:	

III. BACKGROUND INFORMATION

A. Family structure

	FBA	PR 1	PR 2	PR 3	PR 4
Primary Care taker					
Home language					
Number of people living in the household					
Space to hold the sessions					
Level of environmental enrichment					
Recent changes in the household					
Department of Child and Family Services (DCFS) Involvement (if applicable)					
Placement in foster/group home					

B. Caregiver/Member availability for Caregiver Education (Time frame)

	FBA	PR 1	PR 2	PR 3	PR 4
Monday					
Tuesday					
Wednesday					
Thursday					
Friday					
Saturday					
Sunday					

C. Member's availability

	FBA	PR 1	PR 2	PR 3	PR 4
Monday					
Tuesday					
Wednesday					
Thursday					
Friday					
Saturday					
Sunday					

D. Physical and mental health history

	FBA	PR 1	PR 2	PR 3	PR 4
Medical or Physical Problems					
Allergies					
Gender Specific conditions that could impact treatment					
History of hospitalizations and recent injures					
Medications					
Vision and hearing issues					
Sleeping difficulties					
Food selectivity/refusal					
Swallowing food or liquids issues					

E. Current or prior home or outpatient services

Type of Service	Number of Treatment Hours per Week	Dates of Service	Provider

F. Mandatory information - school history and current school based services

	FBA	PR 1	PR 2	PR 3	PR 4	
School Name						
School Start and End times						
School District						
Grade						
Special Education Eligibility						
Date of initial IEP (if available)						
Date of the most recent IEP						
Due date for next IEP						
Did the BCBA attend the IEP in the last reporting period?						
Did the BCBA coordinate care with the school, in the last reporting period? If so, explain.						
Are the services identified in the IEP being provided? Identify any barriers, if any.						
Plans to address any IEP barriers (If applicable)						
Name and contact information of the service provider(s) (funded by IEP) in the school setting (If applicable)						

Current placement (please check the appropriate box)	**FBA**	**PR 1**	**PR 2**	**PR 3**	**PR 4**	**PR5**	**PR6**
• Fully included in a general education classroom							
• General education class with Resource Specialist Support							
• Special Day Program Class with inclusion in general education classes							

• Special Day Program Class with inclusion only during school wide activities								
• Special Education Center								
• Non-Public School Placement (e.g., Help Group)								
Parental concerns related to client's behaviors and academic performance at school	**FBA**							
	PR 1							
	PR 2							
	PR 3							
	PR 4							
If school observation is conducted, teacher concerns related to client's behaviors and academic performance at school								

G. Special Education Related Services Provided at school

➢ **For each type of school based service the client receives at the time of the report indicate the number of minutes/hours per week**

	FBA	**PR 1**	**PR 2**	**PR 3**	**PR 4**	**PR5**	**PR6**
Language and Speech (LAS)							
Occupational Therapy (OT)							
Adaptive Physical Education (APE)							
Physical Therapy (PT)							
Behavior Intervention Consultation (BIC)							
Behavior Intervention Development (BID)							
Behavior Intervention Implementation (BII)							
Deaf and Hard of Hearing (DHH)							
DIS Counseling (Counseling provided by the school psychologist)							
Mental Health Counseling							
Assistive Technology (AT)							
Audiology (AUD)							

Orientation and Mobility (O and M)							
Orthopedic Impairment Itinerant (OI)							
Recreational Therapy (RT)							
Visual Impairment Itinerant (VI)							
Other:							

H. Mandatory information - Care Coordination Involving the Parents or Caregiver(s), School, State Disability Programs and Others as Applicable

FBA	
PR1	

IV. CLINICAL INTERVIEW

A. Parental concerns and priorities

	Problem behaviors	Clinical rationale if not addressed during current reporting period	Skill Deficits	Clinical rationale if not addressed during current reporting period
FBA				
PR1				

V. DIRECT ASSESSMENT PROCEDURES/PROGRESS MONITORING RESULTS

A. Data collection methods

	Dates of data collection	Data Collection Method(s)	Location of data collection	Person(s) collecting data and credentials
FBA				
PR 1				

VI. PREFERENCE ASSESSMENT (PA)

Date of most recent PA	Type of PA	List of most preferred stimuli (must be updated every 6 months)
	☐ Survey/caregiver interview ☐ Paired choice ☐ Single Stimulus ☐ MSWO ☐ Free Operant Engagement Based	

VII. Insert Test Tables and Visual Representation of Client Profile below (e.g., VB-MAPP, Vineland, AFFLS, etc.) with the date it was last administered. (Administered annually)

VIII. Identify measurable goals and objectives that are specific, behaviorally defined, developmentally appropriate, socially significant and based on clinical observation. Domains such as prerequisite skills, communication, daily living skills, etc. <u>Use one box per domain</u>

Domain:			
Target Behavior			
FBA	Baseline level of performance (per goal) based on assessment criteria and clinical observation	Relative strengths Skill Deficits:	
	Individualized measurable goal(s) with estimated date of mastery		
	Generalization criteria		
	Treatment Plan to address the initial goal(s). Evidence based BHT services with demonstrated clinical efficacy /s		
Previous report	Goal 1 Met : ☐Yes ☐ No Goal 2 Met : ☐Yes ☐ No Goal 3 Met : ☐Yes ☐ No	Present level of performance (PLP) based on assessment criteria and clinical observation	

	Generality Criteria for : Goal 1 Met : ☐Yes ☐ No Goal 2 Met : ☐Yes ☐ No Goal 3 Met : ☐Yes ☐ No	List the environmental barriers that hindered meeting the goal:	
		Revised or New Individualized measurable goal(s) with estimated date of mastery. Evidence based BHT services with demonstrated clinical efficacy.	
		Generalization criteria	
		Treatment plan (intervention) to address the revised or new goal	
Current report	Goal 1 Met : ☐Yes ☐ No Goal 2 Met : ☐Yes ☐ No Goal 3 Met : ☐Yes ☐ No	Present level of performance (PLP) based on assessment criteria and clinical observation	
		List the environmental barriers that hindered meeting the goal:	
	Generality Criteria for : Goal 1 Met : ☐Yes ☐ No Goal 2 Met : ☐Yes ☐ No Goal 3 Met : ☐Yes ☐ No	Revised or New Individualized measurable goal(s) with estimated date of mastery. Evidence based BHT services	

		with demonstrated clinical efficacy.	
		Generalization criteria	
		Treatment plan (intervention) to address the revised or new goal	

- **Progress Report Graphs:**

IX. PRESENT LEVELS OF PERFORMANCE FOR PROBLEM BEHAVIORS

- Complete one table for each problem behavior unless problem behaviors are part of a response class hierarchy
- If you are addressing multiple problem behaviors, copy and paste the problem behavior table and complete the information in the table

Target Problem Behavior	
Operational Definition	
Baseline level (collected by clinician, include a baseline graph) **If not observed**, please include clinical steps that will be taken once services	

are initiated to design a function based treatment plan.		
Antecedents that are correlated with the problem behavior(s)		
Utilize evidence-based BHT services with demonstrated clinical efficacy to identify the function(s) of behavior (**FA or conditional probability results- AB & BC graph based on direct observation of a clinician**)		
FBA	Individualized and Measurable Behavior Reduction Goal(s) with estimated date of mastery. Evidence based BHT services with demonstrated clinical efficacy.	
	Individualized and Measurable Alternative Behavior Goal(s) with estimated date of mastery.	
	Generalization criteria	
	Initial Treatment Plan (function based and technological) to address problem behavior(s). Evidence based BHT services	

	with demonstrated clinical efficacy.		
Previous report	**Behavior Reduction** Goal Met: ☐Yes ☐No **Alternative Behavior** Goal Met: ☐Yes ☐No **Generality Criteria:** Behavior reduction: Met: ☐Yes ☐No Alternative Behavior Met: ☐Yes ☐No	Present level of performance (PLP) based on assessment criteria and clinical observation	
		Environmental barriers that hindered meeting the goal and solution:	
		Revised or New Individualized measurable goal(s) with estimated date of mastery	
		Generalization criteria	
		Treatment plan to address the revised or new goal(s). Evidence based BHT services with demonstrated clinical efficacy.	
	Behavior Reduction Goal Met: ☐Yes ☐No **Alternative Behavior** Goal Met: ☐Yes ☐No	Present level of performance (PLP) based on assessment criteria and clinical observation	

Current report	**Generality Criteria:** Behavior reduction: Met: ☐Yes ☐No Alternative Behavior Met: ☐Yes ☐No	Environmental barriers that hindered meeting the goal and solution:	
		Revised or New Individualized measurable goal(s) with estimated date of mastery	
		Generalization criteria	
		Treatment plan to address the revised or new goal(s). Evidence based BHT services with demonstrated clinical efficacy.	

- **Baseline and Progress Report Graphs:**

X. PARENT/GUARDIAN TRAINING

Support and participation needed to achieve the goals and objectives for both member and guardian

FBA	
PR 1	

Guardian Training:

<table>
<tr><td colspan="2">Target skill to be performed by guardian(s)</td><td colspan="2"></td></tr>
<tr><td colspan="2">Baseline level of performance based on clinical observation</td><td colspan="2"></td></tr>
<tr><td rowspan="3">FBA</td><td>Individualized and measurable guardian goal(s) with estimated date of mastery.</td><td colspan="2"></td></tr>
<tr><td>Generalization criteria</td><td colspan="2"></td></tr>
<tr><td>Treatment plan to teach the skill identified in the goal. Evidence based BHT services with demonstrated clinical efficacy.</td><td colspan="2"></td></tr>
<tr><td rowspan="4">Previous report</td><td rowspan="4">Goal 1 Met : ☐Yes ☐ No
Goal 2 Met : ☐Yes ☐ No
Goal 3 Met : ☐Yes ☐ No

Generality Criteria for:
Goal 1 Met : ☐Yes ☐ No
Goal 2 Met : ☐Yes ☐ No
Goal 3 Met : ☐Yes ☐ No</td><td>Present level of performance (PLP) based on clinical observation and measurement</td><td></td></tr>
<tr><td>Environmental barriers that hindered meeting the goal and solution:</td><td></td></tr>
<tr><td>Revised or New individualized and measurable goal(s) with estimated date of mastery.</td><td></td></tr>
<tr><td>Generalization criteria</td><td></td></tr>
</table>

		Treatment plan to address the revised or new goal(s). Evidence based BHT services with demonstrated clinical efficacy.	

- **Progress Report Graphs:**

XI. Summary of overall progress

SUMMARY AND RECOMMENDATIONS				
	PR 1	**PR 2**	**PR 3**	**PR 4**
How many goals have been met in the last reporting period				
How many goals have not been met and had to be modified				
How many goals have been placed on hold because a member lacked a prerequisite skill				
How many goals will be targeted during the next reporting period				

CLINICAL RATIONALE FOR MODIFICATION OF HOURS
CRISIS PLAN
TRANSITION PLAN

DISCHARGE CRITERIA

Note: Please include the following disclaimer in your reports: The content of this report has been thoroughly discussed with client's parent(s). Parent(s) agree with assessment findings, intervention plans, goals, objectives and recommendation. If parents do not agree with any part of your report indicate which parts and the reason for disagreement.

Signature of Qualified Autism Service Provider	Credentials of Qualified Autism Service Provider	Date