

Tidal Consulting and Therapy



Intake paperwork checklist

☐ **Intake Documents**

- ☐ Intake Packet (Completed and signed)
 - ☐ Consent for Services (signed)
 - ☐ HIPPA - Notice of Privacy Practices (signed)
- ☐ Parent Handbook (Signed on last page- can return only last page to Tidal)
- ☐ Tidal Consulting and Therapy Release of Information Form (signed)

☐ **Identification and Financial**

- ☐ Copy of Government-Issued Photo ID (parent)
- ☐ Copy of front and back of insurance card

☐ **Supporting Documents**

- ☐ Diagnostic Report with autism diagnosis
- ☐ Referral for ABA services*
 - ☐ ***NOTE: Referral must be less than 6 months old**
- ☐ Clinical Confirmation Form*
 - ☐ ***NOTE: Must be completed if autism diagnosis provided prior to child being 3 years and 1 day old**
- ☐ Authorization for Behavioral Health and Primary Care Physician to share information (signed)
- ☐ Authorization for ABA provider to release information to Carelon Health (signed)
- ☐ Authorization for Carelon Health to release information to ABA provider (signed)

Tidal Consulting and Therapy



Client Intake Packet

Personal Information

Child's First Name: _____

Last Name: _____

Middle Name: _____

Gender: ☐ Male ☐

Female Date of Birth: ____

SSN: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Mother's Full Name: _____

Date of Birth: _____

Email Address: _____

Phone Number: _____

Father's Full Name: _____

Date of Birth: _____

Email Address: _____

Phone Number: _____

Primary Language Spoken at Home: _____

Who referred you to us? _____

Medical Information

Primary Care Physician's Name: _____

Phone Number: _____

Payment for Services

Insurance Information

Primary Insurance

Subscriber First Name: _____

Subscriber Last Name: _____

Birth Date: _____

Gender: _____

Phone Number: _____

Street Address: _____

City / State / Zip: _____

Insurance Carrier Name: _____

Member ID #: _____

Group #: _____

Relationship to Patient: _____

Secondary Insurance (if applicable)

[Same fields as above]

Authorization Statement:

☐ I authorize Tidal Consulting and Therapy to bill my child's insurance for services rendered.

Signature: _____

Date: _____

Credit Card Information- N/A for Medicaid

Cardholder Full Name: _____

Cardholder Address: _____

City / State / Zip: _____

Credit Card Type:

☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Credit Card Number: _____

Expiration Date: _____

CVC Code: _____

Authorization Statement:

☐ I authorize Tidal Consulting and Therapy to charge my card for copays or balances not covered by insurance.

☐ I will submit payment by check.

Signature: _____

Date: _____

Informed Consent of Services

This section describes the agreement to receive Applied Behavior Analysis (ABA) services, including assessment, treatment, confidentiality, limits of confidentiality, communication expectations, electronic communication, photography/video/audio usage, social skills interactions, illness policy, cancellation policy, discontinuation of services, assessment procedures, treatment provision, treatment updates, and client rights.

(Policy language unchanged; no personal data included.)

Authorization to Consent for Services

I agree to allow my child to participate in ABA services provided by Tidal Consulting and Therapy.

☐ I AGREE and consent to services

☐ I DO NOT AGREE and do not consent

Child's Name: _____

Child's Date of Birth: _____

Parent/Guardian Name: _____

Signature: _____

Date: _____

Consent to Release Information

I authorize Tidal Consulting and Therapy to release and receive relevant treatment information to/from the following individuals or organizations: (ex. OT, PT, Speech, Pediatrician)

- 1.
- 2.
- 3.

Parent/Guardian Name: _____

Signature: _____

Date: _____

Release of Client Records

Authorization to release or access records for purposes including medical care, insurance, education, or legal needs.

Child's Name: _____

Date of Birth: _____

Parent/Guardian Name: _____

Signature: _____

Date: _____

Therapy Non-Compliance Agreement

Outlines attendance requirements, cancellation expectations, consequences of non-compliance, and agency responsibilities.

(Policy language unchanged.)

Parent/Guardian Signature: _____

Date: _____

Telehealth Consent Form

Authorization or opt-out for telehealth services, including supervision and parent training.

☐ I consent to telehealth

☐ I opt out of telehealth

Child's Name: _____

Parent/Guardian Name: _____

Signature: _____

Date: _____

Emergency Contact and HIPAA Acknowledgment

Emergency consent, HIPAA privacy notice acknowledgment, and optional consent for photography/video/audio use.

Parent/Guardian Signature: _____

Date: _____

Client / Family Handbook

Policies and Procedures – Updated January 2026

Includes:

- Admission and intake process
- Family involvement expectations
- Patient rights and responsibilities
- Professional conduct and boundaries
- Clinical policies and supervision
- Attendance, communication, and safety policies
- HIPAA Privacy Notice
- Mandated reporter policy
- Emergency, disaster, and infection control procedures

(All policy content retained; no identifying client data included.)

Proof of Diagnosis

A diagnosis of autism was received on (Date)_____by (Physician)

_____ from (Organization) _____.

- **PLEASE ATTACH DIAGNOSTIC REPORT UPON RETURN OF THIS FORM-**
 - **If Diagnosis was prior to 3 years 1 day of age, please completed the attached Clinical Confirmation form**
- **PLEASE ATTACH A REFERRAL FORM FROM YOUR PHYSICIAN (no older than 6 months)**

Tidal Consulting and Therapy



PARENT & CAREGIVER HANDBOOK

Applied Behavior Analysis (ABA) Therapy Services- Maryland

Welcome

Welcome to **Tidal Consulting and Therapy**! We are honored to partner with your family. This handbook explains our services, policies, and your rights and responsibilities while receiving ABA therapy in the state of **Maryland**.

Our goal is to provide **ethical, evidence-based, and individualized ABA services** that support meaningful outcomes for children with autism and their families.

About Applied Behavior Analysis (ABA)

Applied Behavior Analysis (ABA) is a scientifically supported approach that uses principles of learning to:

- Increase functional and socially meaningful skills
- Reduce behaviors that interfere with learning or safety

ABA services are individualized and data-driven, and progress is continuously monitored and adjusted as needed.

Services Provided

Services may include:

- Initial and ongoing assessments
- Individualized treatment planning
- Direct ABA therapy
- Behavior reduction and skill acquisition programs
- Parent training and caregiver coaching
- Clinical supervision
- Care coordination (with consent)
- Social Skills groups (focus on pre-readiness programs)
- Telehealth services when clinically appropriate

Service Setting

Most services are delivered in our **clinic setting**, in conjunction with Smiley Pediatric Therapy, which allows for:

- Structured learning environments
- Access to materials and peer opportunities
- Increased supervision and collaboration

When authorized and clinically appropriate, services may also occur in:

- The home
- School or community settings
- Telehealth (for supervision and parent training)

Your ABA Team

Board Certified Behavior Analyst (BCBA)

- Conducts assessments
- Develops and updates treatment plans
- Supervises therapy staff
- Provides parent training

- Communicates with insurance providers as required

Registered Behavior Technician (RBT) / Behavior Technician

- Implements treatment plans
- Works directly with your child
- Collects data during sessions
- Communicates session updates to supervisors

Parent / Caregiver

- Participates in parent training
- Communicates relevant changes or concerns
- Supports skill generalization outside the clinic

Parent Training (Maryland Requirement)

Parent training is a **required component** of ABA services in Maryland for both **Medicaid and most private insurers**.

Parent training may include:

- Learning behavior strategies
- Reviewing goals and progress
- Practicing techniques for home use
- Supporting generalization of skills

Failure to participate in parent training may impact authorization or continuation of services.

Attendance & Scheduling

Attendance Expectations

Consistent attendance is required by **Maryland Medicaid and private insurers** to maintain authorization.

Repeated:

- Late cancellations
- No-shows

- Early session

terminations may result in:

- Reduced authorized hours
- Schedule changes
- Discharge from services

Cancellation Policy

- **24-hour notice** is required for cancellations
- Late cancellations and no-shows are documented
- Excessive cancellations may be reported to insurance as non-compliance

Clinic Closures

We follow a posted clinic calendar for:

- Holidays
- Weather-related closures
Families will be notified as soon as possible.

Illness Policy (Clinic-Based)

To protect clients and staff:

- Sessions should be canceled if your child has:
 - Fever
 - Vomiting or diarrhea
 - Contagious illness
- The child must be symptom-free, without the use of fever-reducing medications, for **24 hours** before returning
- Staff may cancel sessions if illness is observed at the clinic

Behavior Intervention & Safety

- All behavior plans are based on assessment and data
- Interventions follow ethical guidelines and Maryland regulations
- **Aversive procedures and corporal punishment are never used**
- Safety and crisis protocols are followed when necessary
- Parents will be notified of significant incidents per policy

Confidentiality & HIPAA (Maryland)

We comply with:

- **HIPAA**
- **Maryland confidentiality laws**
- Insurance privacy

requirements Information is shared

only:

- With written parental consent
- As required for treatment, payment, or healthcare operations
- When legally mandated (e.g., safety concerns)

Mandatory Reporting (Maryland Law)

All staff are **mandated reporters** under Maryland law and must report suspected:

- Child abuse
- Child neglect

Reports are made to the appropriate Maryland authorities when required.

Telehealth Services

Telehealth may be used for:

- Parent training
- BCBA supervision
- Consultation

Telehealth services require:

- Clinical appropriateness
- Written consent
- Compliance with Maryland and insurance regulations

Insurance & Financial Responsibility

Maryland Medicaid

- Services require prior authorization
- Attendance and parent participation are required
- Families must notify us of any changes to Medicaid status immediately

Private Insurance

- Authorizations are required and time-limited
- Families are responsible for:
 - Copays
 - Deductibles
 - Non-covered services

Failure to maintain insurance or financial obligations may result in service interruption.

Communication

We encourage open and respectful communication.

- Clinical concerns: contact your BCBA
- Scheduling or billing questions: contact the office
- Please allow reasonable response time during business hours

Discontinuation of Services

Services may end due to:

- Achievement of treatment goals
- Family request
- Insurance authorization ending

- Non-compliance with attendance or policies
- Safety concerns

A discharge summary will be provided when appropriate.

Client Rights (Maryland)

Families have the right to:

- Dignity, respect, and culturally responsive care
- Participate in treatment decisions
- Access records upon request
- File complaints or grievances
- Receive services free from retaliation

Grievances & Complaints

If concerns arise:

1. Speak with your BCBA
2. Contact the Clinical Director
3. Submit a written grievance if unresolved

All grievances are documented and addressed promptly.

Acknowledgment of Receipt

I acknowledge that I have received and reviewed the **Parent & Caregiver Handbook** for **[Company Name]** and agree to follow the policies outlined.

Parent / Guardian Name: _____

Signature: _____

Date: _____

- ☐ Add copy of insurance card (front and back)
- ☐ Add copy of parent driver's license.
- ☐ Include Diagnostic Report
 - If Diagnosis provided earlier than 3 years, 1 day, complete the Clinical Confirmation Form
- ☐ Include ABA referral (referral less than 6 months old)

Clinical Confirmation Form (CCF)

Instructions: This document is to confirm the diagnosis of Autism Spectrum Disorder (ASD) and is required for the participant to continue ABA services. Please complete the following checklist and include a copy of a visit summary dated within the last six months from the date this form is completed.

This form is necessary **ONLY** in the following circumstance:

Participant was younger than 3 years old at the time of ASD diagnosis AND two years or more have passed since the participant was diagnosed with ASD.

Name of Medicaid Participant: _____ **Date of Birth:** _____

Date of most recent face to face evaluation (must be within the past six months): _____

Section 1		Check one:								
Please complete the following: <i>(a response for each section is required)</i>		Yes	No	N/A						
1. I am one of the following with the training and experience to diagnose ASD (circle one): <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; padding: 5px;">Pediatrician or Developmental Pediatrician</td> <td style="width: 50%; padding: 5px;">Pediatric Neurologist</td> </tr> <tr> <td style="padding: 5px;">Child Psychiatrist</td> <td style="padding: 5px;">Clinical Psychologist</td> </tr> <tr> <td style="padding: 5px;">Nurse Practitioner</td> <td style="padding: 5px;">Neuropsychologist</td> </tr> </table>		Pediatrician or Developmental Pediatrician	Pediatric Neurologist	Child Psychiatrist	Clinical Psychologist	Nurse Practitioner	Neuropsychologist			
Pediatrician or Developmental Pediatrician	Pediatric Neurologist									
Child Psychiatrist	Clinical Psychologist									
Nurse Practitioner	Neuropsychologist									
2. I have attached a copy of my most recent face-to-face evaluation completed with this participant and his/her parent or caregiver within the past 6 months.										
3. If this participant has been receiving Applied Behavior Analysis (ABA) services, I have reviewed his/her progress and response to intervention.										
4. Based on my history, direct observation of the participant, and review of any relevant records, he/she continues to meet criteria for a diagnosis of ASD.										

Section 2		Check one:		
I have observed persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following, currently or by history (must have all 3):		Yes	No	N/A
a) Deficits in social-emotional reciprocity, ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions.				
b) Deficits in nonverbal communicative behaviors used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communication.				
c) Deficits in developing, maintaining, and understanding relationships, ranging, for example, from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers.				

Section 3	Check one:		
1. I have observed restricted, repetitive patterns of behavior, interests, or activities, as manifested by the following, currently or by history <u>(must have at least two)</u> :	Yes	No	N/A
a) Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypes, lining up toys or flipping objects, echolalia, idiosyncratic phrases).			
b) Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat same food every day).			
c) Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interests).			
d) Hyper- or hypo-reactivity to sensory input or unusual interest in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement).			
2. Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning.			
3. I recommend that this participant receive ABA services.			

Please provide any additional information relevant to this participant’s diagnosis and need for ABA services:

I attest that I am the qualified health care professional providing care for this Medicaid participant and the medical necessity information contained in this document is true, accurate and complete, and to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Printed Name: _____Signature: _____Date:_____



Authorization for Behavioral Health and Primary Care Physician to Share Confidential Information

MEMBER CONSENT TO RELEASE CONFIDENTIAL INFORMATION

I, _____ (Member Name) give permission to _____ (Behavioral Health Provider) and my Primary Care Physician _____ (Primary Care Physician) to share information about my diagnosis and / or treatment related to substance abuse, mental health, or medical history, NOT including the results of a blood test for antibodies to the human immunodeficiency virus (HIV). I understand the purpose of sharing information is to help me receive better care.

This consent form expires 90 days from the date of signing and I can choose to cancel it at any time.

Member/Guardian/Authorized Representative

Date

Witness

Date

Member Refusal to Release Confidential Information

I, _____ (Member Name) **DO NOT** give permission to _____ (Behavioral Health Provider) and my Primary Care Physician _____ (Primary Care Physician) to share information about my diagnosis and / or treatment related to substance abuse, mental health, or medical history, including the results of a blood test for antibodies to the human immunodeficiency virus (HIV). I understand the purpose of sharing information is to help me receive better care. I also understand that my refusal to share information does not affect my insurance coverage.

Member/Guardian/Authorized Representative

Date

Witness

Date

This consent form expires 90 days from the date of signing and I can choose to cancel it at any time.



Authorization for Carelon Behavioral Health to Release Confidential Information

Important: By completing all sections of this form you allow Carelon Behavioral Health, Inc. (Carelon Behavioral Health) to disclose health care information to the individuals you identify for up to one year. You may allow Carelon Behavioral Health to share health care information with your family, providers, legal representative, or **anyone** you wish to have access. Please fill in all sections as incomplete forms may be returned.

Please note: It is also important for your doctor to have access to your medical information to ensure you receive the best care possible, including any follow-up care that may be needed. To allow Carelon Behavioral Health the ability to send your health care information to your doctor, complete and sign this form. We will only send information that pertains to your care.

If your request involves alcohol or substance use information, please pay attention to the special instructions in the applicable sections.

SECTION 1: WHOSE HEALTH CARE INFORMATION IS TO BE RELEASED?

I, _____ (Member Name) authorize Carelon Behavioral Health (or any Carelon Behavioral Health subsidiary holding my information) to disclose my health care information as described below.

Additional Member Identifying Information Member ID#: _____ DOB: ____/____/____
Phone Number: _____ Name of Health Plan: _____

SECTION 2: WHO IS TO RECEIVE THIS HEALTH CARE INFORMATION?

Print the Name(s) of person, provider or entity who will be receiving your information and contact information (if known):

Phone number of who will be receiving your information: _____

Is it ok to include information from past, present, and/or future treating provider(s)?: ☐ Yes ☐ No

SECTION 3: WHY SHOULD THIS HEALTH CARE INFORMATION BE RELEASED?

Reason ("At my request" is an acceptable response): _____

Specify, if possible: ☐ Care Coordination/Management ☐ Claim Assistance ☐ Quality of Care Review
☐ Other (Please explain reason): _____

SECTION 4: WHAT HEALTH CARE INFORMATION MAY BE RELEASED?

BY INITIALING the items on the following page, you authorize Carelon Behavioral Health to release specific types of information to the party identified in Section 2 above:



Authorization for Carelon Behavioral Health to Release Confidential Information

____ Mental health information and/or records **(INITIALS REQUIRED)**

____ Alcohol or substance use information and/or records **(INITIALS REQUIRED)**

Optional: ☐ Claims info ☐ Authorizations ☐ Explanation of benefit letters ☐ Denials/Appeals info ☐ Clinical notes

____ HIV/AIDS related information and/or records **(INITIALS REQUIRED)**

____ Other health information, please specify **(INITIALS REQUIRED)**: _____

Special instructions, if any (you may specify provider, date span, service type, etc.): _____

SECTION 5: HOW LONG SHOULD THIS AUTHORIZATION LAST?

This authorization shall be in force and effect **for one year** or until I revoke it, in the manner described below or until **(insert expiration date or event)** _____ *(whichever is shorter)*.

SECTION 6: WHAT ARE MY RIGHTS?

- You have a right to request a copy of this form and to request a copy of the information that is being disclosed.
- You do not have to sign this authorization and your refusal will not affect your benefits unless this authorization is necessary to determine your benefits.
- The information disclosed by this authorization may be at risk for re-disclosure by the recipient and if that happens, it might no longer be protected by federal privacy laws.
- You have a right to revoke this authorization at any time. ***But if you revoke this authorization, the revocation will not affect the disclosure of any information that Carelon Behavioral Health has already sent to the recipient.***
- If you authorized release of alcohol or substance use information to a healthcare organization that is not your treating provider, for the next two years, you have the right to find out who within that organization actually saw your information. You should contact the organization directly for that information.

Please note that if you have authorized the release of ONLY alcohol or substance use treatment records, you may revoke this authorization verbally. Revocation involving all other types of health care records must be in writing.

Signature of the Member or the Member's Legally Authorized Representative*

Date

Print Name

*** NOTE: If you are signing as the individual's Legally Authorized Representative, attach a copy of the appropriate legal document(s) granting you the authority to do so. Examples would be a health care power of attorney, a court order, guardianship papers, etc. A financial or business power of attorney is NOT sufficient.**

Please contact the phone number for behavioral health, mental health, or substance use services on your medical ID card with any questions or to determine where to mail or fax your request.



Authorization for Provider to Release Confidential Information to Carelon Behavioral Health, Inc.

_____(Member Name) _/_/_ (Date of Birth) authorize Carelon Behavioral Health, Inc. (Carelon Behavioral Health) to

☒ Request from and authorize:

(Name/Address or Phone Number) to release/disclose to Carelon Behavioral Health: _____

Method of Release

☒ Telephone/Verbal (Telephone#)-----

☐

U.S. Mail/In-person

☒ Fax# _____

ICONSENT TO THE RELEASE OF THE SPECIFIC INFORMATION CHECKED OFF BELOW:

☒ Discharge

Psychological testing

☐ Psychiatric Evaluation

Progress Notes

☒ summary

☐

☒ results

☐☐☐

☒ Laboratory

☐

☒ Complete Medical

History and

Treatment

Alcohol and Drug

Abuse Information

Other (Please be Specific) Treatment

History of Mental Health

HIV/AIDS Information

***Please note information not specifically checked above is not to be released**

For date(s) of service: From: _____ To: _____

THIS INFORMATION IS NEEDED FOR THE FOLLOWING PURPOSE(S):

☒ Coordination of Care

☒ Case Management

☒ Patient Care

☒ Quality of Care Review
Other (Specify)

I understand that my records are protected under state and federal law and cannot be disclosed without my written consent except as otherwise specifically provided by law. Further, I understand that if my records involve alcohol or drug abuse, they are also protected under Federal Regulation 42 CFR Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records. I also understand that disclosure of HIV/AIDS related information may only be: (1) limited to specific circumstances: and/or (2) restricted by me.

I have read carefully and understand the above statements and expressly and voluntarily consent to disclosure of my confidential health care information (including alcohol and drug abuse records of my condition and HIV/AIDS information, if checked above) to those persons/agencies named above.

I understand that I may withdraw and revoke this consent at any time by notifying Carelon Behavioral Health, either orally or in writing, at the following address:

However, my withdrawal/revocation will not affect the rights of anyone acting in reliance on this consent prior to notice of the withdrawal/revocation. Unless otherwise revoked, this consent will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event, or condition, this consent will remain valid for not more than twelve (12) months from the date this consent was signed.

Carelon Behavioral Health will not condition payment, treatment, enrollment or eligibility for benefits on whether I sign this authorization. I am aware that the information disclosed as part of this authorization and contained in my record may be given to another agency/person if requested.



Authorization for Provider to Release Confidential Information to Carelon Behavioral Health, Inc.

Carelon Behavioral Health will not condition payment, treatment, enrollment or eligibility for benefits on whether I sign this authorization. I understand that by not signing this form, the services provided to me by Carelon Behavioral Health may be limited if benefits cannot be determined. I am aware that the information disclosed as part of this authorization may be re-disclosed and no longer protected under federal or state law.

Signature of Patient, Legal Guardian or Parent

Date

Relationship if not Patient, or if Patient is under 18

Date

Signature of Patient, if under 18

Date

Witness

Date

This information is needed for the following purpose(s):

☒ Coordination of Care

☒ Case
Management

☒ Patient Care

☒ Quality of Care Review
Other (Specify) _____

I understand that my records are protected under state and federal law and cannot be disclosed without my written consent except as otherwise specifically provided by law. Further, I understand that if my records involve alcohol or drug abuse, they are also protected under Federal Regulation 42 CFR Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records.

I have read carefully and understand the above statements and expressly and voluntarily consent to disclosure of my confidential health care information (including alcohol and drug abuse records of my condition and HIV test results, if checked above) to those persons/agencies named above.

I understand that I may withdraw and revoke this consent at any time by notifying Carelon Behavioral Health, either orally or in writing, at the following address:
However, my withdrawal/revocation will not affect the rights of anyone acting in reliance on this consent prior to notice of the withdrawal/revocation. Unless otherwise revoked, this consent will expire on the following date, event or condition: _____. If I fail to specify an expiration date, or condition, this consent will remain valid for not more than twelve (12) months from the date this consent was signed.

Signature of Patient, Legal Guardian or Parent

Date

Relationship if not Patient, or if Patient is under 18

Date

Signature of Patient, if under 18

Date

Witness

Date



Maryland Medicaid ABA Referral Form

Instructions: Referring practice must fill out ALL information below. Please note that referrals for Applied Behavior Analysis (ABA) services must be made by the following qualified healthcare professionals: Developmental Pediatrician, Pediatrician, Nurse Practitioner, Pediatric Neurologist, Child Psychiatrist, Clinical Psychologist, and Neuropsychologist.

Patient Information

Full Name:

DOB:

Maryland Medicaid ID:

Parent/Guardian Name:

Practice Information

Name of Practice:

Practice Phone Number:

Referring Provider Name:

Referring Provider NPI:

Referring Provider Email:

Referral Information

Please check the following box if recommending Applied Behavioral Analysis (ABA) Services

☐ I recommend the above patient receive ABA services

Provider Signature and Credential:

Date:

Practice Stamp: