Autism Spectrum Disorder (ASD) Diagnosis Certification for Requesting Initial Applied Behavior Analysis (ABA) Services

Instructions: Submit this certification with **initial requests** for ABA services along with FA-11E. Do not submit this form with requests for continued service.

Request Date:	
Recipient Name:	Recipient Medicaid ID:

Practitioner Certification Ordering ABA Services: *Practitioner must be a Physician, Physician's Assistant, Advanced Practice Registered Nurse (APRN) or Psychologist acting within their scope of practice.*

A Practitioner acting within their scope of practice as defined by State law certifies the following:

1. This individual is between 0 and 21 years of age and has an established diagnosis of ASD or other related condition for which ABA is recognized as medically necessary.
2. ABA services are required to develop, maintain or restore to the maximum extent practical the functions of the individual for whom they are requested.
3. The individual exhibits excesses and/or deficits of behavior that impede access to age appropriate home or community activities.
4. There is a reasonable expectation that the individual will improve, or maintain function to the maximum extent practical with ABA services.
5. Please identify the diagnostic tool utilized to establish the ASD diagnosis as well as qualifying score. Please check the appropriate box below and enter the individual's score for the diagnostic tool used:

   ☐ Autism Diagnostic Observation Schedule, 2nd Ed. (ADOS-2) Score:_____

   Subscales Scores:_____

   ☐ Childhood Autism Rating Scale, 2nd Ed. (CARS-2) Score:_____

   Subscales Scores:_____

   ☐ Gilliam Autism Rating Scale, 3rd Ed. (GARS-3) Score:_____

   Please indicate the subscales presenting concern observed on the rating sheets:

   _____

   ☐ Fetal Alcohol Spectrum Disorders (FASD) Diagnostic category:_____

   Please indicate the diagnostic system/criteria and/or assessment methods used to determine this diagnostic category: _____

   _____

   ☐ Other: _____ Score:_____

Name of Practitioner: _____

Credentials: _____

National Provider Identifier (NPI): _____

Signature:_____

Date of Diagnosis:_____