Magellan Behavioral Health of Pennsylvania, Inc.
Intensive Behavioral Health Services (IBHS) Assessment

Member's Name: _____ Date of Birth: _____

Medical Assistance ID #: _____ Date Assessment Began: _____

County of Residence: Select One Date Assessment Completed: _____

Date of Written Order: _____

Date Written Order Received: _____

Date Written Order Completed: _____

Intensive Behavioral Health Services (IBHS) regulations state that within 15 days of the initiation of services and prior to completing an Individual Treatment Plan (ITP), a face-to-face assessment shall be completed for the child, youth or young adult by an individual qualified to provide behavior consultation services or mobile therapy services.

IBHS regulations state that within 30 days of the initiation of Applied Behavior Analysis (ABA) services and prior to completing the ITP, a face-to-face assessment shall be completed for the child, youth or young adult by an individual qualified to provide behavior analytic services or behavior consultation—ABA services.

Strengths:

Needs:

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Current Services:

Clinical for all IBHS/ABA Assessments:

Treatment History:

Medical History:

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Development History:

Family History:

Educational History:

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Social History:

Trauma History:

Other Related Clinical Information:

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Developmental, Cognitive, Communicative, Social and Behavioral Functioning:

Cultural Needs:

CANS Assessment Results:

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Other Assessment Tool Results:

CANS Summary: Attach

ABA Assessments (In Addition to Above):

Survey Data gathered from a Parent, Legal Guardian or Caregiver:

Adaptive Skills Assessment (ABA):

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Analysis of Skills Deficits (ABA):

Compilation of observational data to identify developmental, cognitive, communicative, behavioral and adaptive functioning:

Identification and analysis of skill deficits, targeted behaviors or both:

Analysis of Standardized Behavioral Assessment Tool: Attach

Results of Standardized Behavioral Assessment Tool: Attach

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Updated Assessments (For Concurrent and Change of Prescription):

Progress in Current Treatment:

Barriers in Treatment:

Proposed Treatment Adjustments:

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Summary of Written Order Recommendations:

Summary of Treatment Recommendations:

Member Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Provider Signature: _____ Date: _____

Other Signature/Title: _____ Date: _____

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