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| --- |
| **Recipient’s Name: Provider:** [your name/degree/credentials]**Date of Birth: Intake Date:**  [1st billed service]**Month of Service:** [month year] **Hours this month:** [total direct & indirect] **Cumulative Hours:** [total since 7/1]**Medicaid #:**  |
| **SERVICES PROVIDED**  |
| **Direct Services:** 🞎 Behavior Analysis Level I 🞎 Behavior Analysis Level 2 🞎 Behavior Analysis Level 3 |
| Brief description of behavioral service provided, including training, instructions, assistance to caregivers, parent/client response to treatment; significant behavior observed, caregiver performance observed/reported. |
| **Service Date:**  **Time In: Time Out:** **Hrs:** |
| **Summary:**  |
| **Service Date:**  **Time In: Time Out:** **Hrs:** |
| **Summary:**  |
| **Service Date:**  **Time In: Time Out:** **Hrs:** |
| **Summary:**  |
| **Service Date:**  **Time In: Time Out:** **Hrs:** |
| **Summary:**  |
|  |
| **Indirect Services:** 🞎 Behavior Analysis Level I 🞎 Behavior Analysis Level 2 🞎 Behavior Analysis Level 3 |
| List type of activity (behavior plan development, graphing and data analysis, behavior plan revision, attending treatment team or LRC, phone consultation). Documentation/graphing must be billed on actual date when it was done, which is usually in the following month. |
| **Service Date:**  **Start Time: End Time:** **Hrs:** |
| **Summary:**  |
| **Service Date:**  **Start Time: End Time:** **Hrs:** |
| **Summary:**  |

**Provider’s Signature/Credentials: Date**

**Supervisor’s Signature/Credentials: Date**