Medicaid-Funded Applied Behavior Analysis (ABA) Services
Documentation of Compliance with Supplement/Non-Supplant Requirement

Supplement/Non-Supplant Requirement: Medicaid Provider Manual states:

> **"[Medicaid funded ABA Services] may serve to reinforce skills or lessons taught in school, therapy, or other settings, but are not intended to supplant services provided in school or other settings, or to be provided when the child would typically be in school but for the parent's/guardian's choice to home-school their child. Each child's Individual Plan of Service (IPOS) must document that these services do not include special education and related services defined in the Individuals with Disabilities Education Improvement Act of 2004 (IDEA) that are available to the child through a local education agency."**

Purpose: The purpose of this form is to document the scheduling of Medicaid-funded ABA services to ensure that these services supplement and do not supplant the child's existing school services, i.e., general and special education provided by the child's local education agency. Specifically, the ABA provider must coordinate an ABA service schedule that is outside of the child's existing school day schedule. Each child's IPOS must document that these Medicaid-funded ABA services do not include special education and related services

Beneficiary Name: _____ Date Range of Schedule: _____
Date of Birth: _____ Age: _____ CMHSP: _____
School: _____ PIHP: _____

ABA Adaptive Behavior Treatment Schedule (0364T+0365T, 0372T, 0373T +0374T) typically delivered by a Behavior Technician.
May not use time/seat minutes from school schedule. **Note: Complete a new documentation form if school schedule changes.**

Schedule	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
School Day (Record the typical start/stop time)	**Start:** _____ **End:** _____	**Start:** _____ **End:** _____	**Start:** _____ **End:** _____	**Start:** _____ **End:** _____	**Start:** _____ **End:** _____		
Medicaid-funded ABA ABT Service	**Start:** _____ **End:** _____	**Start:** _____ **End:** _____	**Start:** _____ **End:** _____	**Start:** _____ **End:** _____	**Start:** _____ **End:** _____	**Start:** _____ **End:** _____	**Start:** _____ **End:** _____

Signatures

Case Manager/Supports Coordinator (Print Name)	Signature	Date
ABA Service Provider (Print Name)	Signature	Date
Guardian/Caregiver (Print Name)	Signature	Date