pennsylvania
DEPARTMENT OF HUMAN SERVICES

ATTESTATION FOR BEHAVIORAL HEALTH REHABILATION SERVICES PROVIDERS THAT PROVIDE APPLIED BEHAVIORAL ANALYSIS USING BEHAVIORAL SPECIALIST CONSULTANT-AUTISM SPECTRUM DISORDER AND THERAPEUTIC STAFF SUPPORT SERVICES

To the Behavioral Health Rehabilitation Services Provider:

If you provide Applied Behavioral Analysis (ABA) to children with Autism Spectrum Disorder (ASD) using Behavioral Specialist Consultant-Autism Spectrum Disorder (BSC-ASD) services, the individuals you use to provide BSC-ASD the services or the individuals who otherwise oversee the implementation of treatment plans that includes ABA must confirm in writing that they have skills and knowledge related to ABA. The Department has developed a form that is to be completed by these individuals to confirm that they have the specified skills and knowledge related to ABA.

In addition, the individuals you use to provide Therapeutic Staff Support services must understand the basic principles of ABA and have received training to enable them to carry out the specific procedures and techniques used in the treatment plans they are implementing.

Please complete the following if you are providing ABA to children with ASD using BSC-ASD and TSS services. Providers who complete this form will be listed in the **[insert name of provider]** provider directory as Behavioral Health Rehabilitation Services providers that provide ABA.

_____I attest that the individuals **[insert name of provider]** uses to provide BSC-ASD services or otherwise oversee the implementation of a treatment plan that includes ABA have completed the *Confirmation of Knowledge and Skills to Provide Applied Behavioral Analysis* form confirming that they have skills and knowledge related to ABA.

_____I attest that the individuals **[insert name of provider]** uses to provide Therapeutic Staff Support services understand the basic principles of ABA and have received training to enable them to carry out the specific procedures and techniques used in the treatment plans they are implementing.

_____
(Name of Provider)

_____
Signature of Director

_____
Date