New Client:______________________________

Regional Center Vendor Codes

	Type of Session	Vendor Code	Service Code
☐	Behavior Mgmt Assist (ABA)	PL0946	615
☐	Adaptive Skills Training (AST)	PL1137	605
☐	Infant Development Program (IDP)	HL0739	805
☐	Behavioral Respite (Personal Assistance)	PL1725	062

WHO IS THE CLIENT'S FUNDING SOURCE?
(Ask your supervisor if you don't know)

☐ **(1)** Regional Center
☐ **(2)** LA Care Insurance
☐ **(3)** Other Insurance Company

CHOOSE THE CORRECT FORM TO USE
(Ask your supervisor if you don't know)

1 **Parent Verification Form** from the DDS for **Regional Center** clients (2 page Landscape)

PARENTAL VERIFICATION FOR RECEIPT OF BEHAVIORAL SERVICES
DS 6062 (6/2011)
Page 1 of 2

2. Vendor Name: CREATIVE BEHAVIORAL CONSULTANTS, INC.
4. Vendor Phone #: 818-932-9644
Year: 2021

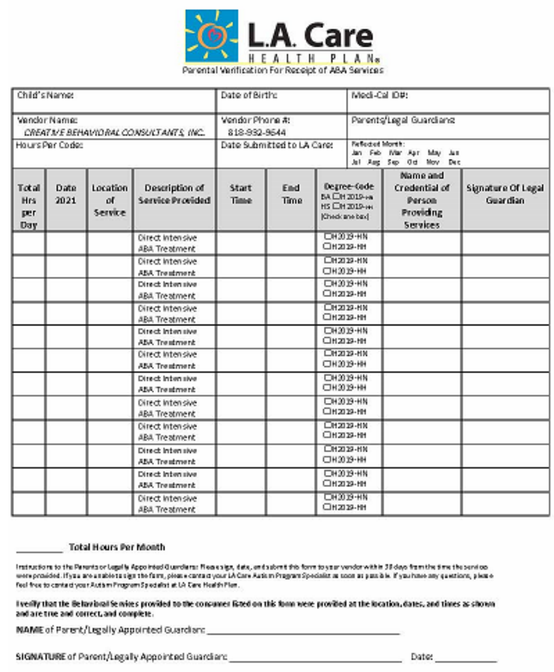
Date	Location of Service	Name & Credential of Person Providing Services	Description of Service Provided	Service Code	Start Time	End Time	Signature of Parent or Legal Guardian

PARENTAL VERIFICATION FOR RECEIPT OF BEHAVIORAL SERVICES
DS 6062 (6/2011)
Page 2 of 2

Name of Parent/Legally Appointed Guardian

Parent or Legally Appointed Guardian Signature   Date

#2 **LA Care Insurance Form**



L.A. Care HEALTH PLAN
Parental Verification For Receipt of ABA Services

Child's Name:	Date of Birth:	Medi-Cal ID#:
Vendor Name: CREATIVE BEHAVIORAL CONSULTANTS, INC.	Vendor Phone #: 818-932-9644	Parents/Legal Guardians:
Hours Per Code:	Date Submitted to LA Care:	Reflected Month: Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

Total Hrs per Day	Date 2021	Location of Service	Description of Service Provided	Start Time	End Time	Degree-Code BA ☐H 2019-HN HS ☐H 2019-HH (Check one box)	Name and Credential of Person Providing Services	Signature Of Legal Guardian
			Direct Intensive ABA Treatment			☐H2019-HN ☐H2019-HH		
			Direct Intensive ABA Treatment			☐H2019-HN ☐H2019-HH		
			Direct Intensive ABA Treatment			☐H2019-HN ☐H2019-HH		
			Direct Intensive ABA Treatment			☐H2019-HN ☐H2019-HH		
			Direct Intensive ABA Treatment			☐H2019-HN ☐H2019-HH		
			Direct Intensive ABA Treatment			☐H2019-HN ☐H2019-HH		
			Direct Intensive ABA Treatment			☐H2019-HN ☐H2019-HH		
			Direct Intensive ABA Treatment			☐H2019-HN ☐H2019-HH		
			Direct Intensive ABA Treatment			☐H2019-HN ☐H2019-HH		
			Direct Intensive ABA Treatment			☐H2019-HN ☐H2019-HH		
			Direct Intensive ABA Treatment			☐H2019-HN ☐H2019-HH		
			Direct Intensive ABA Treatment			☐H2019-HN ☐H2019-HH		

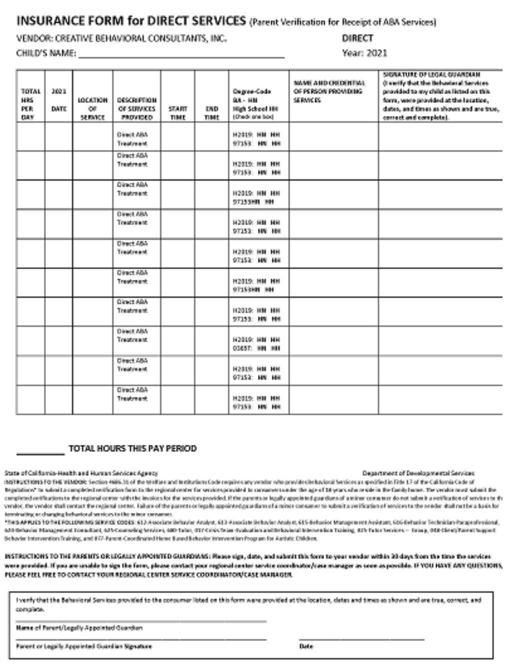
_______ **Total Hours Per Month**

I verify that the Behavioral Services provided to the consumer listed on this form were provided at the location, dates, and times as shown and are true and correct, and complete.

NAME of Parent/Legally Appointed Guardian: ______________________

SIGNATURE of Parent/Legally Appointed Guardian: ______________________ Date: __________

#3 **All other Insurance Companies' Verification Form**



INSURANCE FORM for DIRECT SERVICES (Parent Verification for Receipt of ABA Services)
VENDOR: CREATIVE BEHAVIORAL CONSULTANTS, INC.   **DIRECT**
CHILD'S NAME: ______________________   Year: 2021

TOTAL HRS PER DAY	2021 DATE	LOCATION OF SERVICE	DESCRIPTION OF SERVICES PROVIDED	START TIME	END TIME	Degree-Code BA - HN High School HH (Check one box)	NAME AND CREDENTIAL OF PERSON PROVIDING SERVICES	SIGNATURE OF LEGAL GUARDIAN (I verify that the Behavioral Services provided to my child as listed on this form, were provided at the location, dates, and times as shown and are true, correct and complete).
			Direct ABA Treatment			H2019: HN HH 97153: HN HH		
			Direct ABA Treatment			H2019: HN HH 97153: HN HH		
			Direct ABA Treatment			H2019: HN HH 97153HN HH		
			Direct ABA Treatment			H2019: HN HH 97153: HN HH		
			Direct ABA Treatment			H2019: HN HH 97153: HN HH		
			Direct ABA Treatment			H2019: HN HH 97153HN HH		
			Direct ABA Treatment			H2019: HN HH 97153: HN HH		
			Direct ABA Treatment			H2019: HN HH 0365T: HN HH		
			Direct ABA Treatment			H2019: HN HH 97153: HN HH		
			Direct ABA Treatment			H2019: HN HH 97153: HN HH		

_______ **TOTAL HOURS THIS PAY PERIOD**

State of California-Health and Human Services Agency   Department of Developmental Services

INSTRUCTIONS TO THE PARENTS OR LEGALLY APPOINTED GUARDIANS: Please sign, date, and submit this form to your vendor within 30 days from the time the services were provided. If you are unable to sign the form, please contact your regional center service coordinator/case manager as soon as possible. IF YOU HAVE ANY QUESTIONS, PLEASE FEEL FREE TO CONTACT YOUR REGIONAL CENTER SERVICE COORDINATOR/CASE MANAGER.

I verify that the Behavioral Services provided to the consumer listed on this form were provided at the location, dates and times as shown and are true, correct, and complete.

Name of Parent/Legally Appointed Guardian

Parent or Legally Appointed Guardian Signature   Date