

New Client: _____

Regional Center Vendor Codes

	Type of Session	Vendor Code	Service Code
<input type="checkbox"/>	Behavior Mgmt Assist (ABA)	PL0946	615
<input type="checkbox"/>	Adaptive Skills Training (AST)	PL1137	605
<input type="checkbox"/>	Infant Development Program (IDP)	HL0739	805
<input type="checkbox"/>	Behavioral Respite (Personal Assistance)	PL1725	062

#2 LA Care Insurance Form



Child's Name: _____ Date of Birth: _____ Med-Cal ID#: _____

Vendor Name: CREATIVE BEHAVIORAL CONSULTANTS, INC. Vendor Phone #: 818-932-9644 Parent/Legal Guardian: _____

Hours Per Code: _____ Date Submitted to LA Care: _____

Total Hrs per Day	Date 2021	Location of Service	Description of Service Provided	Start Time	End Time	Degree-Code (BA, CH, IDP, MS, CR)	BA, CH, IDP, MS, CR (Check one box)	Name and Credential of Person Providing Services	Signature of Legal Guardian
			Direct Intensive ABA Treatment			CH202P-HH			
			Direct Intensive ABA Treatment			CH202P-HH			
			Direct Intensive ABA Treatment			CH202P-HH			
			Direct Intensive ABA Treatment			CH202P-HH			
			Direct Intensive ABA Treatment			CH202P-HH			
			Direct Intensive ABA Treatment			CH202P-HH			
			Direct Intensive ABA Treatment			CH202P-HH			
			Direct Intensive ABA Treatment			CH202P-HH			
			Direct Intensive ABA Treatment			CH202P-HH			
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			Direct Intensive ABA Treatment			CH202P-HH			
			Direct Intensive ABA Treatment			CH202P-HH			
			Direct Intensive ABA Treatment			CH202P-HH			
			Direct Intensive ABA Treatment			CH202P-HH			
			Direct Intensive ABA Treatment			CH202P-HH			
			Direct Intensive ABA Treatment			CH202P-HH			

Total Hours Per Month _____

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 service was provided. If you are unable to sign this form, please contact your LA Care Account Program Specialist as soon as possible. If you have any questions, please feel free to contact your Account Program Specialist at LA Care Health Plan.

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: _____

SIGNATURE of Parent/Legally Appointed Guardian: _____ Date: _____

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)

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

PARENTAL VERIFICATION FOR RECEIPT OF BEHAVIORAL SERVICES DS 5892 (03/21)

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1. Consumer Name: (FNU) _____ (DPO) _____ (UC) # _____

2. Vendor Name: CREATIVE BEHAVIORAL CONSULTANTS, INC.

3. Vendor # _____ 4. Vendor Phone # 818-932-9644

5. For Services Provided: Month _____ 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 Legally Appointed Guardian

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

PARENTAL VERIFICATION FOR RECEIPT OF BEHAVIORAL SERVICES DS 5892 (03/21)

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#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, CH, IDP, MS, CR) (Check one box)	NAME AND CREDENTIAL OF PERSON PROVIDING SERVICES	SIGNATURE OF LEGAL GUARDIAN (I verify that the behavioral services provided to my child on listed on this form, were provided at the location, dates, and times as shown and are true, correct and complete).
			Direct ABA Treatment			H210P HH HH		
			Direct ABA Treatment			97133P HH HH		
			Direct ABA Treatment			H210P HH HH		
			Direct ABA Treatment			97133P HH HH		
			Direct ABA Treatment			H210P HH HH		
			Direct ABA Treatment			97133P HH HH		
			Direct ABA Treatment			H210P HH HH		
			Direct ABA Treatment			97133P HH HH		
			Direct ABA Treatment			H210P HH HH		
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			Direct ABA Treatment			97133P HH HH		
			Direct ABA Treatment			H210P HH HH		
			Direct ABA Treatment			97133P HH HH		
			Direct ABA Treatment			H210P HH HH		
			Direct ABA Treatment			97133P HH HH		

TOTAL HOURS THIS PAY PERIOD _____

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

INSTRUCTIONS TO THE VENDORS: Section 4959.31 of the Welfare and Institutions Code requires any vendor who provides Behavioral Services as specified in Title 17 of the California Code of Regulations to submit a completed verification form to the regional center for services provided to consumers under the age of 18 years who reside on the family home. The vendor must submit the completed verifications to the regional center with the invoices for the services provided. If the parents or legally appointed guardians of a minor consumer do not submit a verification of services to the vendor, the vendor shall contact the regional center. Failure of the parents or legally appointed guardians of a minor consumer to submit a verification of services to the vendor shall not be a basis for terminating or changing behavioral services to the minor consumer.

"This applies to the following Service Codes: 612-Behavior Analyst, 613-Associate Behavior Analyst, 615-Behavior Management Assistant, 618-Behavior Technician-Managerial, 620-Behavior Management Consultant, 625-Counseling Services, 668-Tutor, 677-Case Team Evaluation and Behavioral Intervention Training, 680-Tutor Services - Group, 682-Child/Parent Support Behavior Intervention Training, and 677-Phase-Coordinated Home Based Behavior Intervention Program for Autism Children."

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.

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: _____