Washington State

Autism Center of Excellence (COE)

Quick Start Guide

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Washington State Medical Home Partnerships Project

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***Note**: This PDF guide has internal and external links to direct you to additional information. Click on the table of contents below to skip to a particular section or click embedded cross-references to jump to a section of the guide. If you notice a broken link, errors, or have suggestions for content, please email us at autismcoe@uw.edu.*

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OVERVIEW OF CHANGES AND UPDATES BY VERSION NUMBER/RELEASE DATE

Version 1.0, released February 2024: Initial version released.

Version 1.1, released June 2024*:* Correcting typos/grammatical errors and improving clarity; Increasing detail in Diagnostic Evaluation section to include more about different models of care, expanded procedures, and additional primary care autism diagnostic training resources; Increasing detail in the Feedback to include resources from the Autism Treatment Network, how to communicate with families and individuals about the diagnosis, and using a strengths-based and neurodiversity-affirming approach; Expansion of Referrals and Follow-up section to include more information about educational supports; Expansion of Appendix E. to include additional evaluation models; Updates to Appendix I. Screening and diagnostic tools to add missing/remove outdated tools, adjust formatting to make it more accessible, and update incorrect costs for tools.

Version 1.2, released January 2025: Checked and updated broken links throughout the document, with special attention to Appendix C. Washington State and Other Resources. Added information on DDA and SSI in the Referrals and Follow-up section, as well as the Appendix C. Washington State and Other Resources. Updated research evidence for primary care autism evaluations in Diagnostic Evaluation section and corrected a link that was directing to an incorrect article. Added new COE lived experience presentations to Appendix B. COE Provider Presentations at Autism COE Trainings. Updated Appendix K. to indicate additional billing provider types for codes 90791, and new codes for mental health providers to capture feedback or follow-up consultations.

Version 2.0, released May 2025: Made minor edits to main body text throughout, addressing typos, grammatical errors, and content flow; updated language to be more strengths-based and neuro-affirming throughout. Added Other resources for education in autism diagnostic practices and Research on autism evaluations in primary care at the end of main body. Fixed formatting on flowchart in Appendix A. Primary Care Autism Clinic Proposal that covered details of workflow. Added an indication of whether resources are available in other languages to Appendix C. Washington State and Other Resources. Updated Appendix I. Screening and diagnostic tools to include additional tools (e.g., Q-CHAT, CASD, ASD-PEDS), as well as reorganized the table to more appropriately reflect the tool types and age ranges. Updated Appendix E. to include more specific workflow details (e.g., visit times, tool used, billing and practice type) and highly detailed examples of specific primary care and School Medical Autism Review Team (SMART) workflows. Reorganized the COE Google Drive Folder to increase ease of navigation and update available documents, including but not limited to, adding intake packets and forms, documentation templates and examples, research articles and best practice guidelines, interview and observational guidelines, and referral and billing documents.

INTRODUCTION

Welcome, current or future Washington State Autism Center of Excellence (COE) provider! Thank you for your interest in improving access to quality care for autistic individuals and their families. You are choosing to be part of a thoughtful and impactful group of primary care providers (PCPs), behavioral health clinicians, and other partners who are working together to decrease the long, inequitable waits for autism diagnostics and services for children and youth with Medicaid insurance in our state. Families are grateful and appreciative of your work, especially in providing diagnostic evaluations, which serve as the gateway to accessing essential services and supports.

This guide is designed to help you build your Autism COE practice and inform your decisions; it has a variety of sections that we hope will be a helpful resource as you continue learning. It is not designed to replace continuing education, such as ECHO Autism Washington or training in Appendix I. Screening and diagnostic tools . Instead, our goal is to give you an introduction to getting started in a systematic way. Throughout this guide, external links are embedded so you can explore certain sections or topics in more depth if you desire. This guide also includes internal links to appendices with templates, workflows, billing codes, etc. so you don't have to start from scratch.

We have a responsibility to support our autistic community in an informed, collaborative, and ethical way. Confirming (or ruling out) a diagnosis of autism can have a profound impact on an individual, and we need to approach the work with professional and cultural humility. That means starting slow. Many COEs limit evaluations to current patients and young children, which is most in line with current research. Others with additional training may see patients in their broader clinic or health care system. Whatever you choose, the knowledge you gain working with autistic patients will also help you as a medical home or specialist provider. With 1 in 31 children being identified as autistic (CDC, 2025), you are already serving this population intentionally or not.

As a first step, we encourage you to fully understand the role and requirements of an Autism COE provider serving the Medicaid-eligible population under the Washington Administrative Code (WAC). As you continue to learn, use this guide to help you plan your practice and take it one a step at a time. Build your practice slowly, gaining experience and confidence as you go. There are many individuals and resources beyond this guide to set you up for success through Washington INCLUDE. Thank you again for your willingness to help and your dedication to learning!

With great appreciation and thanks from the COE training team and Quick Start Guide authors: Karís Casagrande, PhD, Kate Orville, MPH, Jim Troutman, MD, and Jim Mancini, MS CCC-SLP

> *"COE work has been some of the most rewarding work I've done in a long time in terms of people appreciating what you are doing for them."*
>
> *– Jim Troutman, MD, Snohomish County*

GETTING STARTED

Obtaining Buy-in from your Administration

Participating in diagnostic evaluations and meeting the individualized needs of autistic youth and their families can be time-consuming and costly. **However, you are already serving these patients**. At 1 in 31 children identified with autism (Shaw et al., 2025), your practice already sees autistic youth, many of whom are on long waitlists for diagnostic evaluations or struggling to access appropriate care. It can be difficult to get approval and support from your administration to do this work in a sustainable way, but it is an important first step in getting started as a COE.

When advocating with your administration to better serve autistic patients and their families or to grow your practice to accommodate these families, some talking points to emphasize are:

- **Positive impact**. Families who can see providers that already know their family - and can work with them long term – experience greater continuity of care. This work is an important part of serving as a medical home and providing comprehensive care to patients.
- **Reducing waitlists**. There are long wait times for evaluation at tertiary care centers in Washington state. These waitlists can be over two years. Delayed diagnosis leads to delayed access to appropriate supports, resulting in significant stress and reduced opportunities for intervention. Early identification leads to better outcomes for individuals and their families.
- **Increasing equity**. Primary care is often the location with the best connection to underserved populations. Many families are unable to travel to tertiary care centers or cannot afford private evaluations. They rely on primary care to serve as a medical home and access support.
- **Research and policy**. The American Academy of Pediatrics (AAP) supports autism diagnostics for PCPs and pediatricians alongside regular screening and surveillance. Research (e.g., Sohl et al., 2022) demonstrates the accuracy of PCP diagnoses with training. Furthermore, cost analysis has shown that earlier diagnosis relates to reduced long-term costs (Vu et al, 2023).

Before you approach your administration:

- **Be prepared**. Think about what the process would look like and your staffing needs. Consider writing a formal proposal with this information *(Appendix A)*. You may want to bring examples of appointment templates, billing codes, and reimbursement rates *(see other Appendices)*.
- **Share successes**. Share that other community clinics have been successful in implementing this work in their setting *(Appendix B)*. Clinics can set boundaries around referrals to keep the work manageable. For example, many practices start with current patients or internal referrals only and focus on younger children. Clinics can also control the number of appointments per week or month, so that providers are not overwhelmed by the work.
- **Be persistent**. Multiple conversations are often needed to get the ball rolling. Identify allies who can help you advocate for change, such as members of the Washington INCLUDE Collaborative, or connect with other COEs and their administrators who have made it work.

See Appendix A. Primary Care Autism Clinic Proposal for an example of a comprehensive proposal to begin a primary care autism diagnostic clinic with goals, logistics, costs, reimbursements, and process workflow built in.

See Appendix B. COE Provider Presentations at Autism COE Trainings for presentations given by other Autism COE providers, which are relevant to those starting a new practice or addressing common barriers in practice settings.

See AAP's tip sheet on Autism Diagnosis in Primary Care for ideas on setting up your practice for autism diagnostics.

Identifying Community Partners and Resources

Remember, you do not need to do this alone! Identifying providers from other disciplines and settings to collaborate with can lead to multi-disciplinary evaluations that are considered best practice. It is also important to be aware of the resources available to support families and individuals both locally and across the state before, during, and after their evaluation.

To get started, ask yourself:

What is your scope of practice? You do not need to evaluate every child with possible autism, especially those who may require more specialized diagnostic evaluation due to complicating factors. By doing evaluations that are within your scope of practice, such as with younger children or those with more clear presentations as current research supports, you are freeing up space for more complex children to be seen at tertiary care sites in your region. (*See Referral and Triage section for more information on how to determine your scope of practice and triage patients.)*

Are there local providers who can complete an additional assessment? If your review of records, clinical interviewing, and observational assessment leave you unsure of the diagnosis, partner with someone to gather more data. Consider local psychologists, speech-language pathologists, occupational therapists, behavior analysts, Early Support for Infants & Toddlers (ESIT) systems, and local school districts. These providers may have training in administering and interpreting specific Appendix I. Screening and diagnostic tools, or can provide you with additional information to report using validated tools like the CARS-2. (*See Diagnostic Evaluation section for more information on components of a comprehensive evaluation and possible tools to use.)*

Is there a local School Medical Autism Review Team (SMART) or coalition to support you? Many communities already have COEs partnering with community partners (early intervention, schools, public health, family support etc.) to provide multidisciplinary evaluations and/or improve communication and coordination from screening to diagnosis to support services. Connect with work already happening locally or get help bringing in new partners to support autism evaluations in your clinic or community through SMART. (*To learn more click here or email Kate Orville, MPH)*

Who can I go to when I have questions? It is helpful to know who else in your community is doing this work, so you can ask them questions when they come up. This might be another provider in your organization, such as a developmental behavioral pediatrician or behavioral health provider, or a colleague from another agency with more experience doing this work, such as another COE. You can connect to others through ECHO programs with the Washington INCLUDE Collaborative or joining a SMART community. Consider creating a consult group in your region! You can also reach out to the Partnership Access Line (PAL) for consultation as needed.

What are my local community resources? Consider what services and supports are available to families in your area. It is important to gain more information about what is available to share with families following the evaluation. Resources can cover a range of topics such as evidence-based interventions, educational navigation, financial support, parent education, or social and recreational opportunities. We recommend having your region's Parent-to-Parent or Children and Youth with Special Health Care Needs (CYSHCN) coordinator's information to share with families, as they are likely to be familiar regional resources; HelpMeGrow can also support families of younger children navigating resources. *See Appendix C. Washington State and Other Resources.*

Designing your Workflow

There are many options for how to structure the evaluation process, which need to be tailored to your specific context. Consider what is realistic and sustainable to your situation. If you try to be a one-stop-shop and do it all, you will likely not have enough time and burn out. It is vital to have ancillary staff to support the process. And while there is no one single model for an evaluation, there are some best practices to keep in mind as you think about what is going to work for your clinic. And remember, you can always adjust your model after you have begun.

To get you started, here are some questions you should ask yourself and your team:

What age group do we start with? We recommend beginning evaluations with younger children before you see older and possibly more complex patients, as there is more accessible free training, guidelines, and research evidence for working with that population. For those working with older children, consider starting with more straightforward cases, and find opportunities for shadowing or more hands on training. *See Referral and Triage for more information on how to identify cases*.

How many evaluations are realistic? Many providers already have a full schedule. Ask yourself: How much time am I able dedicate to conducting evaluations? How often can I do this? How spread out do those visits need to be? It is important to start slowly so you can learn the process, but remember that the best way to become confident doing autism evaluations is to do autism evaluations. Try to schedule regularly enough to gain experience, knowing with time it gets easier.

Who is a part of your team? Autism evaluations have a lot of moving parts, from processing and triaging referrals, scheduling appointments, conducting intakes, doing the evaluation interviews and observations, documenting, billing, and providing follow-up to individuals and their families. Determine who is part of the process. For example, who will be calling families, scheduling visits, and collecting records? If families have questions, who should they speak to? Who is following up with families about accessing resources? Have regular meetings with this team to check in.

How can we make our space accessible? Many primary care spaces are not designed for conducting autism evaluatiions. Consider how to make your space welcoming and accessible. For example, you may have a room set up differently with age-appropriate toys for play-based observations (*see Appendix D. Evaluation set up tips, toys, and observation examples*). You might also have a sensory friendly waiting area or a toolkit available (*see Autism Sensory Strategies, Information, and Toolkit (ASSIST) for information about sensory differences and strategies*).

What model of evaluation is best for our practice? Again, there is no one size fits all evaluation model. Some clinics do half-day visits, while others have multiple shorter visits (or even as many 30 minute visits as is needed over time!) to allow for collecting outside information, maximize billing, and cover documentation time. Additionally, some use a single discipline model (e.g., private practice psychologists), multidisciplinary approach (common in primary care with referrals to community providers or through the SMART mode), or an interdisciplinary team (common at tertiary care centers). Consider whether you are able to do multi-disciplinary team assessments (e.g., collaborating with 0-3 Early Support for Infant and Toddlers (ESIT) providers, school staff, SLPs) or whether there is staff to assist families completing forms and gathering records (e.g., community health workers, medical assistants, or other administrative staff).

See Appendix E. for ideas about how to set up and structure your workflow.

Components of a Comprehensive Evaluation Process

Referral and Triage

One of the first barriers to overcome when getting started with COE work is understanding which cases are within your current scope of practice, and which fall outside of it. You also want to consider whether you will focus only on current patients, internal referrals, or referrals from outside your practice. There is always room for growth, but it helps to identify a place to start!

Many PCPs are most prepared to evaluate younger children already in their practice and choose to start here. In fact, research shows that PCPs who receive additional training in autism can be just as accurate as specialists when making a diagnosis of autism for young children (e.g., McNally Keehn et al., 2023; Penner et al., 2023; Sohl et al., 2023). There are many factors that contribute to this. There are a greater variety of accessible or free diagnostic tools and questionnaires that can support primary care autism evaluations with younger children. Additionally, younger children presenting for evaluation often have a relationship with a service or school system (e.g., ESIT, developmental preschool) and there is accessible documentation on development and behaviors through an IFSP or IEP. ESIT or school teams can also complete questionnaires that gather information in different contexts. Lastly, these teams may be able to help families complete paperwork or prepare for the visit, and afterward, guide them to their local resources.

There has not yet been research looking into accuracy of primary care autism evaluations for older or more complex patients, but existing research suggests that non-specialists struggle with accurate rule-outs for autism (*meaning that they rule out autism when a specialist would not*). When evaluating older individuals, there is greater variability in autism symptomology, increased differential diagnoses, and additional history to consider. Penner et al (2017) reviewed clinical guidelines highlighting the wide variation in decision making around workflow, diagnostic process and recommendations. Another review (Abrahamson et al., 2021) of various guidelines, policies, and pathways for evaluations highlights the complexities of serving such a diverse population, and offers suggestions for timely, quality, and person- and family-centered care to those in need of autism diagnostic services and supports. The National Institute for Health and Clinical Excellence (NICE) in the UK provides guidelines for diagnosing children up to age 19, and has specific examples of signs and symptoms of possible autism listed by age group (*for a summary of their recommendations on what to look for and when to refer, click here*). Holland Bloorview has similar age-based guidance for structuring your diagnostic evaluations and decision making.

Even with this information alongside appropriate training and continuing education, it can be hard to decide where to start. Heather Buzbee, ARNP, CPNP, PMHNP, a COE provider at Sea Mar Community Health Center, recognized confusion regarding which patients primary care autism evaluations are appropriate for. In response, she developed the Autism Primary Care Complexity Triage (APCCT) tool (*see Appendix F*. Buzbee Autism Primary Care Complexity Triage (APCCT) tool). The APCCT provides a framework providers can use to determine their readiness to evaluate patients based on several facilitating or complicating factors, such as age, gender

identity, language of care, records access, medical or psychiatric co-occurring conditions, and psychosocial vulnerabilities that can guide your triage process.

Intake Process

Having a clear intake process, typically consisting of a packet of paperwork for families to review and complete prior to their first appointment, significantly reduces the amount of time required for administrative staff and providers to complete evaluations. An intake packet can include information about what to expect, questionnaires to complete, release of information (ROI) forms, etc. (*See Appendix G*. Intake packet example). You can also create different packets by age or language. This ensures that when a family is scheduled, you have everything you need to complete the visit.

Consider having an electronic version of the intake that can be completed and returned via a HIPAA-compliant system like REDCap or Qualtrics; this makes information immediately accessible to the diagnostic provider and reduces the need for managing paper records. Another option is to make a "fillable" form (i.e., one that does not need to be printed or scanned to complete, but can be directly typed into) that can be completed and returned via your Electronic Medical Record (EMR) or encrypted email. If you do have an electronic intake, you will want to include additional instructions such as how to open and return the packet so it goes to the right place.

An intake packet could include:

Clinic Information. Provide families and individuals with information about what to expect during their visit, such as how long the process will take (e.g., how many visits, how long they are, and how far apart they tend to be scheduled) and what team members are involved (e.g., first meeting to collect background information with one provider before meeting with another provider for an observational assessment). You can also provide information about clinic policies and procedures, insurance coverage and billing, and payment expectations.

Screening Questionnaire. Decide whether families will complete an autism screening tool as part of their intake process. Screening tools can help while triaging appointments to different team members. For example, higher scores may move a patient directly into an evaluation visit as their caregiver is seeing significant autistic characteristics, while lower scores may benefit first from a developmental interview to understand concerns. You may also find a screener has already been completed with ESIT or through another provider, which is why they were referred to you.

History Questionnaire. Having families complete a medical, developmental, and psychosocial history form in advance can help the team expedite the screening, interview, and evaluation process. Having this information prior to a visit can help the team plan for the evaluation, such as what additional questions to ask, what records to collect, and what tools to use.

Release of Information (ROI). If this child is being served by other agencies, it can help to have the family complete an ROI as part of the intake process, so that your team can start to request records or open communication with those providers. Have two forms pre-populated – one to get information back and one to send information afterward – and include both in the intake packet.

Consider having additional pre-filled ROIs ready for the feedback appointment so that the family can request sharing the document directly with whomever the family wants.

Outside information. You should include a request for ESIT, special education, or other evaluation records, which often include necessary cognitive, communication, and adaptive testing. You can also include forms for families to give their child's teachers and providers (with the accompanying ROI for any follow-up as described above). For example, the Social Communication Observation Tool (developed by WhatcomTakingAction) can be completed by a child's teacher or therapist to gather information about their observations. Include clear steps for how forms can be returned to your team (e.g., a fax number or HIPAA-compliant online process). Since you cannot guarantee a family will share the forms or whether they will be returned, you may want to choose a general information form like the one above that can be printed as many times as needed, rather than forms that require purchase. You can always follow-up with another questionnaire afterward.

See Appendix G. Intake packet example for what you might include, such as clinical information and a history questionnaire for parents to complete. Additional intake packet materials, such as screening questionnaires and outside information forms, can be found in the COE Quick Start and Supporting Materials Google Drive folder.

Diagnostic Evaluation

Scheduling your Visits

Scheduling visits in a way that fits with your workflow is key. Having control over your own schedule can be very helpful; otherwise, work closely with your scheduling team so that you have oversight of how scheduling is unfolding. Consider a pre-screening process for potential patients to make sure they are appropriate for your scope of practice before scheduling fills your slots. In addition to a pre-screening process, consider how you will have ongoing communication with your scheduling team. It is much easier (and less stressful for both staff and families) to delay initial scheduling than to correct the problem after a patient is incorrectly put onto the schedule.

If you cannot control your own schedule, you may be able to build pre-screening criteria (e.g., age, language of care, whether there are multiple diagnoses, whether certain paperwork is completed first, etc.) and state that all appointments must be scheduled for a certain amount of time out so you can review prior. You may also choose to give schedulers a list of patients you have already pre-screened, but this may only work if you are scheduling fewer appointments.

Here are some additional considerations for scheduling:

Contact information. The Washington State Health Care Authority (HCA) maintains a list of Autism COE providers that is updated monthly. It is important to make sure that the contact person, phone number, and eligibility criteria (e.g., internal referrals only, children under 5) on that list are accurate. This information should be checked regularly and can be easily updated with a simple email to the HCA ABA COE program manager (ABA@hca.wa.gov).

Clinic model. Consider your overall clinic model and workflow. Are you doing dedicated evaluations that have longer dedicated appointment times or are you fitting visits into a more traditional primary care model with shorter appointments happening over several weeks? Are you doing single discipline evaluations, referring to additional providers, or working with a team? More appointments with multiple providers require more complex scheduling practices but may fit better into primary care. For example, most COEs do evaluations across 2 to 4 30-minutes visits.

Administration and documentation time. Evaluations require significant behind the scenes work that are not part of the face-to-face visit. Depending on how you are billing the visits, you may need to block time on the same day as your appointment in order to be reimbursed for that documentation time; if you bill CPT codes *(as opposed to E/M codes)* you can capture that time.

Support families and schedulers. Your scheduling or admin team is the group that has the most contact with families before a visit. Make sure to support your team by providing them with the information that families may ask about, such as what to expect from a visit, how long it will take, what they need to do in advance, etc. Ideally, this information is included in your intake packet, but many families often get overwhelmed or lose paperwork and may prefer to ask a scheduler.

Ask about unmet needs. Many families have additional unmet needs and may require extra support to attend or participate in their appointments. For example, do you have an easy way to determine whether a family will need an interpreter present for the visit? And have you accounted for the additional time it would take to conduct your visit with an interpreter? Additionally, consider transportation barriers and needs, or families who may need additional reminder calls for their appointment. You may choose to provide an overview of the supports you offer to all families to let them know you want to work with them around their needs.

Conducting your Evaluation

There are a number of best practice guidelines and recommendations (e.g., American Academic of Pediatrics, Canadian Paediatric Society, National Institute for Health and Clinical Excellence, National Research Council), which emphasize the need for comprehensive evaluation of multiple domains of development. While specific diagnostic tools provide reliable, quality information for your assessment, you may not have access to the same tools as tertiary care or research clinics. Remember that best practice also includes timely access to care in local communities and there is evidence that PCPs can diagnose autism as accurately as specialists for younger populations. In addition, your ability as a PCP to follow patients and build relationships over time surpasses what can be accomplished at tertiary care centers in regard to care planning following the diagnosis.

An important step in conducting your evaluation is identifying and assigning roles to each member of your evaluation team. Patients, families, and caregivers should be considered the central members of your team, working alongside others such as medical providers (e.g., primary care providers, doctors, nurses, psychiatrists, developmental pediatricians, neurologists, etc.), behavioral health providers (e.g., occupational, speech, physical therapists), psychologists, and administrative staff (e.g., front desk staff, schedulers, clinic director, etc.).

When conducting your evaluation and making decisions about which tools to use, you also need to consider how to collect information around three essential components of a comprehensive process: 1) requesting records and reviewing information from those familiar with the patient outside the family where possible (e.g., teachers, therapists, childcare providers); 2) interviewing on medical, developmental, family, and social history as well as autism symptomology; and 3) completing a structured observation to directly assess autism symptomology.

1) Record Review. Ask previous evaluations and service records, such as the early intervention Individualized Family Service Plan (IFSP) or school Individualized Education Plan (IEP). Outside therapy records (e.g., speech or occupational therapy) are also helpful. These records often

contain information on developmental, cognitive, language, and/or adaptive functioning, which are important to include in your decision making. You can also use a brief questionnaire, such as the Teacher/ Provider Interview Form, to collect information from school, daycare, or therapists. For older individuals, consider gathering employment and occupational information as well.

2) Detailed Interview. In addition to general interviewing focused on medical, developmental and psychosocial history, a structured autism diagnostic interview will help you ask questions related to symptoms associated with ASD and identify strengths and weaknesses. This interview is also an opportunity to explore family readiness for a diagnosis and perspective on their child's strengths and challenges. Keep in mind that a formal DSM-5 checklist is require by most payors, so your interview needs to touch on all parts of the diagnostic criteria. This is one reason why using a structured and validated interview guide can be beneficial.

3) Structured Observation. There are many validated observation tools, which provide reliable, quality information for your decision-making process, so consider how to access them whenever possible. You may choose to partner with another provider to complete a formal observation like an ADOS-2, STAT, or ASD-PEDS, or develop strategies you can use in the office for an observation of social interaction and behavior associated with ASD (*see Appendix D for ideas of activities to elicit behaviors for younger children; see NICE guidelines or Holland Bloorview for activities for school-age or older children*) that you can report on a validated tool like the CARS-2. There are training opportunities on some of these tools in Washington State. WA INCLUDE often can provide information regarding these trainings. When you are deciding what tools to use, you may also consider what is needed by the payor. For example, some may require a specific tool in order to authorize services based on your diagnosis.

It is important to remember that a diagnostic tool is more than just a score! And, importantly, it is not appropriate to diagnose or not diagnose autism based solely on a specific tool or score. If you partner with another provider to complete a formal observation, such as an ADOS-2, ensure that you hold a brief team consultation to review the findings, ask about what was observed, and understand why a specific score was obtained. (*Note: Even an ADOS-2 score is not a diagnosis. It is a piece of information that should be included alongside other information in your clinical decision making and reporting the specific ADOS-2 score is not recommended for this reason*).

In addition to the above areas which are necessary for an autism diagnostic evaluation, many families benefit from additional testing related to cognitive and adaptive functioning (especially since a recent measure of adaptive functioning is *required* for the DDA application and eligibility process). Cognitive assessments are often done as part of special education evaluation, though this is not always the case. And while you may not be able to administer a cognitive evaluation, you can include a measure of adaptive development like an ABAS-3 in your evaluation process.

See Appendix H. COE Evaluation Requirements to ensure you are completing all aspects that are required for a comprehensive autism diagnostic assessment.

See Appendix I. Screening and diagnostic tools for information on evaluation tools for different age groups.

Documenting your Evaluation

After you complete your evaluation, you will need to document your findings. Having the appropriate documentation ensures that a family can use their evaluation report to obtain the recommended services. Using a template to document your evaluation can also help increase

documentation speed, ensure that all the appropriate information is included in the final report, and improve consistency between staff members if multiple people are involved (Bahrami et al., 2025).

If you use an EMR like EPIC, consider using SmartPhrases (also known as dot phrases). You can also use SmartLists to pre-populate a list of resources and other go-to information (e.g., local Parent to Parent coordinator or ESIT agency by regions, parent advocacy organizations, school resources, common community resources, referral scripts for Speech Therapy or ABA, etc.). The American College of Emergency Physicians has a great tutorial on how to build this.

As part of your report (which should review all relevant information collected through record review, clinical interviewing, and observation), you *must* include a description of how the individual met DSM-5 criteria for autism. Use a Clinical Diagnosis: DSM-5 Checklist at the end of your report to make this information easily accessible for payors to locate within the document.

Remember, COE requirements are related specifically to families seeking ABA services through Medicaid. Private insurance companies have different requirements to reimburse for ABA or cover other services. If you are working with a private insurance company that requires a specific validated tool for ABA and you are not able to complete something such as the ADOS-2, you may want to consider other tools like the CARS-2, which is an organized way of scoring information collected through your record review, interviews, and behavioral observations.

See Appendix J. Documentation and report templates for documentation examples (including a template you can copy/paste into your notes as well as an example of an EPIC template with embedded SmartPhrases and SmartLists)

Billing your time

Billing is a critical component of creating sustainable COE work. Autism evaluations involve a significant amount of work outside of face-to-face encounters, such as record review, evaluation prep, and report writing. Learning how to bill for these elements allows you to maximize your reimbursements and bill for as much of your time as possible. The autism clinic proposal in Appendix A offers one framework for a billing structure. However, billing practices vary based on several factors (e.g., provider type, workflow, payor, clinic), so it is important to explore the various billing practices and codes that may be accessible to you; there is also a potential to get reimbursement for the support work of a community health worker. Consider reaching out to ECHO Autism Washington and other COE providers to ask about their billing practices or set up a meeting with the billing representative in your organization to get details about what is possible. Additional examples of billing and visit workflows can be found in Appendix E. Evaluation Models and Workflows

See Appendix K. for information about billing codes by provider types.

Feedback

Communicating the Diagnosis

Once you have completed your evaluation, schedule a time to review and communicate your findings, which often (*but not always*) results in giving a specific diagnosis such as Autism, ADHD, or Global Developmental Delay. Effectively communicating the diagnosis can be one of the most challenging aspects of the evaluation; even if you aren't able to confirm or rule out a diagnosis, discussing the need for further monitoring or screening, and making needed referrals, creates more opportunities for individuals to receive the supports and services that can help them thrive!

The Autism Treatment Network (ATN) and the Autism Intervention Research Network on Physical health (AIR-P) have developed a toolkit with guidelines and video examples to help prepare providers to communicate a diagnosis of autism and support families on their next steps. This can also help when thinking about making developmental diagnoses more broadly. As families can arrive at the feedback visit with varying levels in their understanding of the process and their readiness to accept the diagnosis, before you begin the feedback, ask yourself:

> **What do they already know about autism?** Throughout the evaluation process, you should gather information related to the caregiver's understanding of autism and expectations about the evaluation process. Knowing who referred the family for the evaluation can be a hint. For example, families referred by the school or a provider may have less knowledge of evaluation process or a diagnosis of autism, while those who self-refer may have done more research on it.
>
> **What is their readiness for a diagnosis?** Understand whether the family feels that the diagnosis of autism is a possibility, or if there are other diagnoses they are expecting to receive such as ADHD or anxiety. Families may have strong beliefs about whether their child is or is not autistic, which might differ from your clinical impressions. Listen for these beliefs during the interview. This can guide how you approach feedback and prepare for potential areas of disagreement.
>
> **What else might influence their understanding and readiness?** Understanding and readiness for a diagnosis can be influenced by many factors. One of the largest factors is a family's cultural and linguistic background (especially if it differs from your own). Other factors that can impact a family's understanding of autism and readiness can be whether this is their first or only child, socio-economic status, presence of disability or mental health issues in the family, their profession (e.g., teacher, paraprofessional, therapist, nurse, doctor), and more.

During the feedback, consider *how* you are communicating information with families and whether they are understanding the points you are communicating. For example, it can help families if you prepare a few take-aways or next steps, and consider using the repeat back strategy (asking families to repeat back those points throughout). You also want to make space for families to problem solve around any potential obstacles or disagreements that may come up. Throughout, make sure you are listening, acknowledging, and validated the family's concerns and wishes. The feedback session is not just about communicating a diagnosis, but building a relationship of trust so that a family feels confident and empowered to continue their journey.

It is also important to use a strengths-based, neuro-affirming approach as part of empowering families and newly identified autistic people. Often, evaluations and feedback heavily focus on

the deficits-based medical criteria that go along with a diagnosis. While it is important to understand the skills gaps and challenges a person may face, it is equally important to highlight strengths, build an understanding of neurodiversity, and support hope for the future. One activity that may encourage this mindset is to review a handout like this one and discuss which specific areas of strength an individual or family resonates with. You might also choose to discuss diagnostic criteria using visuals like this one that highlight the individual differences and unique presentation that every autistic person has. The UW Autism Center has some great free webinars for families and autistic people on understanding and supporting a strengths-based and disability affirming approach to autism. The Autistic Self Advocacy Network (ASAN) and Autistic Women & Nonbinary Network (AWN) also have neurodiversity affirming toolkits written *by* autistic people *for* newly diagnostic autistic people, than can be helpful to share with families.

What to Do When You Don't Diagnose (or You're Not Sure)

There will be times where you are not confident confirming or ruling out a specific diagnosis, or where you need to gather more information before you can make a decision. It is important to clearly communicate those needs and next steps with the family, so they understand the plan going forward. It is okay to say you don't know. It is also okay to say you are not able to make a diagnosis at the time, and that you can re-evaluate in the future. This is an advantage of being a primary care provider; you can follow that family over time to continue gathering information, address their concerns, make referrals for services that may support the individual in the meantime, and revisit the diagnostic question in the future. Again, it is important to be aware of the extent of your knowledge and training, and practice cultural and professional humility.

Autism is a complex disorder that manifests in many ways. While research shows that non-specialists are quite accurate in making autism diagnoses in young children, it also shows that non-specialists often rule out autism where a specialist would not. This is especially true for patients with complex or atypical presentations. For example, those who speak another language or have different cultural norms, have significant cognitive or language delays, have medical or psychiatric co-morbidities, or were assigned female at birth, are all often under-identified as autistic and/or misdiagnosed with other conditions. Ruling out a diagnosis of autism early on makes it harder for a family to seek evaluation in the future. When you are unsure or the family continues to have concerns about autism, it is recommended that referrals be made to tertiary care centers or other specialists that have experience evaluating complex cases and can provide multi-disciplinary assessments. You can also state that "results are inconclusive for autism spectrum disorder at this time; future re-evaluation is needed for diagnostic clarity." Using a Appendix F. Buzbee Autism Primary Care Complexity Triage (APCCT) tool can help you to understand various levels of complexity in autism diagnostic and guide you in determining appropriate next steps, such as referring to a specialty site for follow up.

Avoid falling into the "wait and see" trap, which does not provide a plan for addressing concerns and can feel invalidating. Identify what the primary obstacles to learning are (e.g. communication, sensory, behavior, motivation, social-emotional skills etc.) and use that information to make referrals to needed services (e.g., speech, OT, early intervention, special

education). Early concerns are a significant and consistent indicator of later developmental diagnoses; families know when something is wrong even if they are not sure what it is. Be humble and aware that even with additional training, we are still human and make mistakes. Families and individuals are the expert in their own experience, and you should consider providing an option for a second opinion or a comprehensive or multidisciplinary neurodevelopmental assessment.

Here are some different pathways to consider:

Consider alternate diagnoses. When you are unable to confirm a diagnosis of autism, but know that multiple developmental milestones are not being met, a diagnosis of Global Developmental Delay (GDD) can help them get qualified for services (*note: GDD only applies under age 5*). Previously, providers could use a provisional ASD diagnosis, but many payors are no longer reimbursing under that label outside of Medicaid. Instead, GDD is helpful as domains affected include language, social, or adaptive skills. For older children presenting for an evaluation, they may also experience challenges related to language, cognition, behavior, and mood. Consider testing or referrals to specialists who can explore other those diagnoses before ruling out ASD.

Get consultation. If you are a PCP, you may have access to the Partnership Access Line (PAL), a child and adolescent psychiatric consultation service for questions such as diagnostic clarification, medication adjustment or treatment planning. You can also present your case at ECHO for input.

Gather more information. If you did not already, reach out to others who work with this child, such as childcare providers, school staff, or other therapists to get their input. You may want to gather general observations, before giving more detailed or formal questionnaires. This is so you can make sure to get information from someone who knows the child and family well.

Refer for additional evaluation or observation. You may need to refer the child to an SLP or OT for evaluation. You might also refer to ESIT or the school district, where they can evaluate cognitive, adaptive, and social-emotional functioning. Remember, a diagnosis is not required for many services but are based on developmental needs. Many COEs refer patients for these evaluations prior to evaluating for autism so they have the necessary developmental information.

Refer to a tertiary care specialist. If you are not confident in confirming or ruling out autism, or this client has a high number of complexity factors that make the diagnosis more challenging, refer them to a tertiary care center. As many centers will not do re-evaluation, consider how you document your findings so follow-up is accessible to families, such as stating that *"current results are inconclusive and require additional evaluation."* When you send a referral, include all information and observations gathered for the provider to use in their follow-up evaluation.

Referrals and Follow-up

After completing an evaluation, the next step is to provide recommendations, referrals and a follow-up plan for this individual regardless of their diagnosis. If they are a patient in your practice, this could mean scheduling a follow-up with you or another provider in your practice about one or two months out for answering any questions that have come up or support them with service navigation if they are struggling. If this youth has a different primary care provider, you may want to encourage the family to follow up with that provider and have them complete an ROI so you can send the report and your recommendations directly to that provider.

Family Education, Support, and Advocacy

Receiving a diagnosis of autism or another neurodevelopmental disability can be challenging for many families. It changes the way they may understand their child's strengths and challenges, and introduces the need for navigating different systems and building a new set of skills that they would not otherwise need. Part of your recommendations and referrals should include connecting that family to an organization that can help them process this information, learn about their child's diagnosis, and guide them in accessing community supports. Your local Parent-to-Parent or CYSHCN public health coordinator is a great first step for getting a family connected, as they are often the most familiar with the services and supports available in their region; HelpMeGrow is another resources that can support families of younger children navigate resources as well. There are also many other resources for parent education, support, and advocacy through the Seattle Children's Autism Center Patient and Family Education website.

See Appendix C. Washington State and Other Resources for a list of common organizations and informational resources you can share with families, as well as resources specific to culturally and linguistically diverse families.

Early Intervention and Educational Supports

Services through the public school system is often the primary support for a child and their family. In some areas with limited community-based therapies and resources, schools may be the *only* support for your patient and their family. Special education includes ESIT services for children under three years of age and support through local school districts from age 3 –21 when appropriate. Remember that **a diagnosis is NOT required** to initiate ESIT or school services; services are based on needs. This also means that **having a diagnosis *does not* automatically qualify children** for services. For example, there are three requirements for special education: 1) the student must have a disability, 2) the disability adversely affects educational performance, and 3) the student's needs cannot be met through general education alone.

For early intervention (0-3) access, families can contact HelpMeGrow for support. Families of older children can request an evaluation in writing through their local school district; providers can also place the referral. OSPI provides a helpful template for this. It is important to note that the school is required to respond to the request within a specific number of days, but that a request does not guarantee an evaluation or services. PAVE has helpful guidance for families around accessing special education. Families may also find it helpful to contact the OSPI Special Education Parent & Community Liaison or the Office of the Educational Ombuds (OEO) for more individualized support or more information about this process and what to expect.

When educational evaluations are conducted, they should be comprehensive and include cognitive, communication, motor/sensory, adaptive, and social domains when there are concerns across areas of development. Not all autistic individuals qualify for special education services. You can provide support for your families by writing a letter that describes the areas of concern that have been identified and recommend an evaluation to determine eligibility for services. However, keep in mind that the school determines eligibility, and that special education is only required to help meet educational expectations rather than general developmental needs.

Many autistic children or those with other disabilities can (and should!) be supported in the general education environment. Schools can provide support to students outside of special education, such as through a 504. These supports can be created through communication and collaboration with the educational team. Tips for establishing a collaborative partnership with schools can be found here. Potential academic supports that can be offered can be found here.

Community-based Therapies

Depending on the child's identified obstacles to learning and what is available in your community, referrals may be available for community-based therapies. These can include speech, occupational and physical therapies, therapy using principles of applied behavior analysis (ABA), mental health therapy or counseling, social skills groups, parent education and training, etc. Another common referral is for medication consultation and/or management. The National Professional Development Center on ASD has information about evidence-based practices for providers. The Autism Society is another resource that has neurodiversity affirming and family focused information on therapies, as well as a toolkit for having conversations with providers (*you can find the toolkit under ABA services, but this toolkit can help with any service!*).

Identify what is available in your community so you can inform the families you work with. One option is to explore the county public health department's CYSHCN webpage. Most counties have a CYSHCN coordinator who is knowledgeable about autism and the local resources available; if you are not sure how to find what you are looking for, reach out to them. You can also have the family call their insurance company and get a list of providers on their plan. The Washington Mental Health Referral Service can also support families in identifying mental health providers (and ABA or other COE providers!) who take their insurance and are currently accepting patients.

Applied Behavior Analysis (ABA)

There are many misconceptions and misunderstandings about ABA. Simply put, ABA is an individualized behavioral therapy approach informed by frequent data collection and review that combines a variety of evidence-based strategies with the goal of teaching skills for independence and reducing interfering behaviors. Less simply put, provision of ABA by a Board-Certified Behavior Analyst (BCBA) and their team involves the use evidence-based behavioral strategies and interventions, while taking systematic data to determine effectiveness of treatment, seeking to make informed data-based decisions to alter and adapt treatment as needed to meet the needs of each individual learner. ABA aims to decrease life-interfering behavior through consistent individualized interventions, while also teaching positive, adaptive behaviors.

Making a decision to access ABA can be complicated for families and individuals, as this intervention has demonstrated moderate to strong effects across research, but more and more information is circulating within the autistic community identifying concerns with intervention. The Arc of King County has a series called Unpacking the ABA Debate that is helpful to both parents and providers. The Autism Society also designed an ABA Resource toolkit to help equip families with the knowledge and information they need to make informed decisions about ABA.

Referrals for ABA are based upon medical necessity. As identified by the Washington State Health Care Authority (HCA), ABA services are considered medically necessary when other less intrusive interventions and treatment has been unsuccessful, and the child's condition is known to be responsive to ABA based on current research. Medicaid requires very specific language and information in an order for ABA. This information is what guides the COE evaluation process. You can also consult the Washington Administrative Code (WAC) guidelines around ABA.

> **Navigating private insurance.** Private insurance companies have varied requirements and needs to cover ABA services. For example, some companies require specific evaluation tools to be reported in the order. You may want to confirm with your most common private payors what their requirements are. For families of youth 17 an younger, the Washington Mental Health Referral Service is a great tool they can use to locate ABA services in their community. The Washington Autism Alliance (https://washingtonautismalliance.org/) has helped many families advocate for insurance coverage for diagnostic evaluations and ABA-based therapies.
>
> **Navigating Medicaid.** Families with Medicaid should follow the ABA Medicaid Coverage Checklist (additional languages available on the Seattle Children's Autism Center Patient and Family Education Page, under Applied Behavior Analysis) to request an ABA case manager. There is a script that families can follow when making the request, as well as a place to keep track of any phone calls and follow-up steps needed.

See Appendix L. Medicaid ABA order template for autism and non-autism ABA referral templates you can use. Additional ABA templates, such as those for private insurance, are in the Autism Resources Google Drive.

Availability and accessibility of ABA services across the state are variable and simply not available in some locations. In areas where ABA is not accessible, one option may be telehealth services where a family can receive consultation and coaching from a BCBA remotely. Providers such as speech-language pathologists and occupational therapists can provide supports in some areas of development (communication, sensory/motor, social, adaptive behavior) and are often more accessible through school districts and local hospitals. Other providers, such as child psychologists, are also often trained to integrate behavioral methods similar to those in ABA in their approach to working with parents and autistic individuals (for example, through a program like RUBI). If there is a treatment team in place, consider having a BCBA consult with the team on their treatment plan. There are even free online, self-directed programs like the UC Davis Autism Distance Education Parent Training (ADEPT) that a family and their provider can work through together.

Resource support

Many families also need support in accessing additional resources to support their child and family. Navigating these services can be challenging. In response to this need, Shayla Collins developed a brief list of key financial, transportation and recreation resources to support people with intellectual and developmental disabilities and their families. This list includes information such as accessing disability parking permits, prescriptions for diapers, travel benefits, recreation opportunities, and more. Miss Shayla's list, which was designed by a parent for use by families and individuals with disabilities, can be accessed here in English and Spanish.

The Developmental Disabilities Administration (DDA) is a Washington State Department of Social and Health Services (DSHS) program that supports individuals with disabilities across the lifespan. Not all individuals with disabilities qualify for DDA supports. As of October 2024, DDA eligibility for individuals with a diagnosis of autism is based on adaptive functioning (i.e., daily living skills and skills for independent living). Many families may also explore eligibility for Supplemental Security Income (SSI), which is a monthly payment for low-income individuals with disabilities. Informing Families provides family-friendly information regarding DDA or SSI.

Another financial support for autistic people and their families in Washington is Ben's Fund, which provides low-income families of autistic youth up to 25 years of age with up to $1,000 each year. This fund is meant to cover therapeutic equipment, services, or technology. Their application process and eligibility guidelines can be found here.

THANK YOU!

Thank you for beginning your journey to better support autistic individuals and their families. With an estimated 3% of the population being autistic, it is necessary for all providers to have knowledge and skills in supporting their patients with autism and their families. The more COE providers we have in our state, the more knowledge and expertise is shared so that families are able to get the care they need at the right time and in the right place. This is best done when close to home and with people who have knowledge of the local resources and community.

Please continue to learn with us and your peers across Washington state. We invite you to join a Project ECHO learning cohort through the WA INCLUDE Collaborative or University of Washington On Time Autism Intervention Project (0-3) to help you connect with those active in your community. There are also many other ECHO Autism communities across the country that can provide more continuing education. You may also want to connect with your communities' SMART collaborative or other regional COEs. It is easier (and more fun) to grow together.

Thank you for joining the community of providers and professionals who are taking on COE work. You are certainly making a difference! Please reach out to us via email at autismcoe@uw.edu if you need additional support or have questions about this work.

Other resources for education in autism diagnostic practices

- **Best practice guidelines and recommendations** in Autism Diagnostic assessments from the American Academic of Pediatrics, Australian National Guidelines, Canadian Paediatric Society, National Institute for Health and Clinical Excellence, and National Research Council.
- **Diagnostic resources and training** from Vanderbilt Kennedy Center Treatment and Research Institute for Autism Spectrum Disorder (TRIAD) Diagnostic and Care Management Resources for Medical and Other Pediatric Providers (*provides resources including the (TELE)ASD-PEDS , diagnostic decision making supports, modules for autism-specific clinical skills, clinical documentation and workflow examples, and more*), Holland Bloorview Kids Rehabilitation Hospital Autism Spectrum Disorder Diagnostic Guidance Documents (*guidance for age-based behavioral observations, cultural competence, and family-friendly recommendations*), and Global Autism Interactive Network (GAIN) (*professional workshops aimed at enhancing skills in assessing Autism Spectrum Disorder (ASD) such as differential diagnosis in autism or age-based differences*).
- **Books focusing on autism diagnostic practice** such as Is this Autism? A Guide for Clinicians and Everyone Else as well as A Companion Guide for Diagnosing, Essentials of Autism Spectrum Disorders Evaluation and Assessment, and Differential Diagnosis of Autism Spectrum Disorder.
- **Training in specific tools** such as those for young children (ASD-PEDS/TELE-ASD-PEDS; RITA-T; STAT) or older children/adults (ADOS trainings, also offered in Spokane or Seattle; MIGDAS-2; Observation based on the CARS-2, contact Mike Bunis, PsyD (bunism@wustl.edu) with the WashU IDDRC)

Research on autism evaluations in primary care

You can find copies of these articles on the COE Quick Start and Supporting Materials Google Drive folder.

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APPENDICES

Note: You can download an editable word document with all of the appendices at https://medicalhome.org/docs/COE_quick_start_AppendicesOnly.docx

Appendix A. Primary Care Autism Clinic Proposal

Note: Word document version of all appendices https://medicalhome.org/docs/COE_quick_start_AppendicesOnly.docx

Intent: Develop and implement a dedicated Autism Clinic within COMPANY NAME to support families in need of autism diagnostic and support services and facilitate a referral mechanism for primary care providers in the Pacific NW region.

Goal: Pilot a model that provides consistent care between COMPANY NAME autism providers that is efficient and cost effective and scalable, thus allowing implementation on more regional or national level over time. This model will satisfy COMPANY NAME goal of expanding Biopsychosocial services in Primary Care.

Background:

- In 2023, the CDC reported that approximately 1 in 36 children in the U.S has autism spectrum disorder (ASD).
- Most children are still being diagnosed after age 4, though autism can be reliably diagnosed as early as 18-24 months.
- Autism affects all ethnic and socioeconomic groups.
- Minority groups tend to be diagnosed later and less often.
- Average wait list at Seattle Childrens Autism Clinic is 2-3 years and 9-24 months at Providence Childrens Center in Everett. (UPDATE WAIT TIMES AND CHOOSE TERTIARY CENTERS IN YOUR REGION)
- Early intervention affords the best opportunity to support healthy development and deliver benefits across the lifespan.
- Early diagnosis of autism helps patients to access vital developmental services at an early critical age of learning, diagnosis also guides families so they are able to provide best care for their children.
- Autism diagnostic options are disappearing at an alarming rate making outside referrals more and more difficult and further expanding wait times.

Providers:
DISCUSS YOUR CREDENTIALS HERE – TRAINING, BOARD CERTIFICATION, INVOLVEMENT IN AUTISM WORK

Care Model:
Plan is to serve pediatric patients from DISCUSS SERVICE AREA. We can provide this service for patients with an estimated wait time of CHOOSE BEST ESTIMATE, which is much less than the current situation in the community.

Based on community and best-practice standards, the evaluation for autism is a 6–8-hour process (including both face-to-face and administrative work) that takes place over 2-3 visits. Due to the time commitment for these visits, it is difficult to do this work within the template of a regular schedule of pediatric primary care.

Our providers have agreed to a standard for autism evaluation visits which aligns with what is provided in the community.

1st visit 3 hours – collecting information, interviewing parent(s), reviewing clinical records, writing the first report
2nd visit 3 hours – standardized testing and observation, evaluation of testing, and writing second report
3rd visit 1 hour – visit with the family to discuss report and treatment plan

Clinic Expenses:
Paid clinic coordinator 4 hours/week
Office space FILL IN ESTIMATE HOURS OF IN OFFICE USE
Provider reimbursement as noted below- averaging FILL IN BEST FIGURE per full 7-hour work-up
Supplies - $1000/year for new kits or evaluation tools CUSTOMIZE FOR YOUR NEEDS
Marketing MOST PRACTICES WILL LIKELY NOT NEED TO ADVERTISE DUE TO DEMAND BUT INCLUDE A DOLLAR FIGURE IF YOU PLAN OUTSIDE MARKETING

Standard Work/Medicaid Reimbursement:

NUMBERS BELOW BASED ON 2023 RATES - UPDATE ACCORDINGLY. ALSO, IT IS APPROPRIATE TO CHOOSE A DIFFERENT MODEL OF CARE DELIVERY TO MEET YOUR SPECIFIC CLINIC NEEDS SO ADJUST MODEL AND NUMBERS BELOW ACCORDINGLY. MOST IMPORTANT THOUGH, YOU WILL LIKELY NEED TO MAKE THE MODEL RETURN SOME POSITIVE CASH FLOW TO CONVINCE YOUR CLINIC TO ADOPT THE PROGRAM

1st Visit: 3-hour clinic appointment - first visit comprised of collecting historical information, detailed parent interview impressions, reviewing clinical records, and writing the first report.

- Billing reimbursement
- 99215 - 50 minutes - Medicaid pays $166.45
- Bill G2212 – 15-minute incremental codes total 8 codes for the next 2 hours to finish the interview and write the report the same day. $24.96 each increment x 8 = $199.68
    - TOTAL COLLECTED = $366.13

2nd Visit: 3-hour clinic appointment - do standardized testing and observation (either virtual or in person), write final report.

- Billing reimbursement
- 99215 - 50 minutes - $166.45
- G2212 x 8 to finish observation and write report = $199.68 same as noted above
    - TOTAL COLLECTED = $366.13

3rd Visit: 50 minute clinic appointment - parent debrief about impressions and report. Then discuss a treatment plan.

- 99215 - $166.45

TOTAL FOR ALL 3 VISITS AND COMPLETE WORK UP = $366.13 + $366.13 + $166.45 = $898.71

Provider Reimbursement Proposal:

- Provider reimbursement proposed at $100/hr, costing $700 (7 hours) per patient evaluation, which includes all 3 visits.
- As per Medicaid reimbursement, will make $898.71.
- **Positive variance of $198.71** per patient evaluation or better (for commercial patients)

Note:

- Commercial patients may have higher reimbursements
- This would be a service for COMPANY NAME; this can potentially increase patients within our clinic who will establish with PCP for this service.
- 245 outgoing referrals in 2022 (Approximately 20/month) EXAMPLE ONLY- USE YOUR DATA HERE
- Develop scripting for pricing for commercial patients in the future

Compensation:

Hourly rates, providers will submit hours biweekly or monthly to the compensation department for pay

- Per Diem Rate - $100/hour, total $700 per each complete evaluation consisting of 3 visits (NOT ALL CLINICS WILL OFFER A PER DIEM OPTION BUT IF SO, CHOOSE APPROPRIATE HOURLY RATE TO FIT YOUR BUDGET)
- Providers on productivity
    - Clinicians who are paid on productivity can do autism evaluations as part of their work schedule
    - They will be paid based on WRVUs per the routine provider compensation model

Provider Schedule:

Provider schedule will vary and will depend on the visit they are booked for, but a typical 8-hour day can look like this:

- AM Schedule
    - One - 3-hour visit (this can be either 1st or 2nd visit)
    - One - 1-hour visit (this will be the 3rd visit)

- PM Schedule
    - One - 3-hour visit (this can be either 1st or 2nd visit)
    - One - 1-hour visit (this will be the 3rd visit)
- Total visits per day: 2-4
- Total hours per day: 4-8

Notes on Interested Providers: INCLUDE INFO HERE ON PREFERRED SCHEDULE AND HOURS OF WORK AND WHETHER IN OFFICE OR ONLINE EVALUATIONS OR BOTH AND LANGUAGES SPOKEN BY PROVIDERS

Referral Process: Patients would be internally referred to the autism clinic through Epic EXAMPLE DISCUSS YOUR REFERRAL PROCESS IF DIFFERENT

The autism clinic requests a dedicated administrative support person (clinic coordinator) budgeted initially for 4 hours per week to handle incoming referrals, send out needed intake paperwork, collect additional reports from school or other appropriate providers, answer questions from families and schedule appointments. **It is imperative this work NOT be handled through a resource center as it is too complex and will not fit under their standard work.**

The dedicated autism providers will manage the referral list, follow up with families as deemed necessary and work with the administrative coordinator to facilitate and expedite appointments. Once paperwork is returned in full, the clinic coordinator will call and schedule the evaluation.

For commercial patients, the clinic coordinator will be letting the patients know in advance to check with their insurance company if the services are covered – YOU NEED TO DEVELOP YOUR OWN SCRIPTING WITH YOUR FINANCE/BILLING DEPT FOR HOW COMMERICIAL PATIENTS ARE BILLED AND HANDLED AND OUTLINE HERE

Coding/standard workflow and compensation are the same for all providers interested in this work as well as for state and privately insured patients. FLOW DIAGRAM- SEE NEXT PAGE – THIS IS AN EXAMPLE ONLY THAT YOU CAN CUSTOMIZE TO FIT YOUR CLINIC PLANS

Summary:

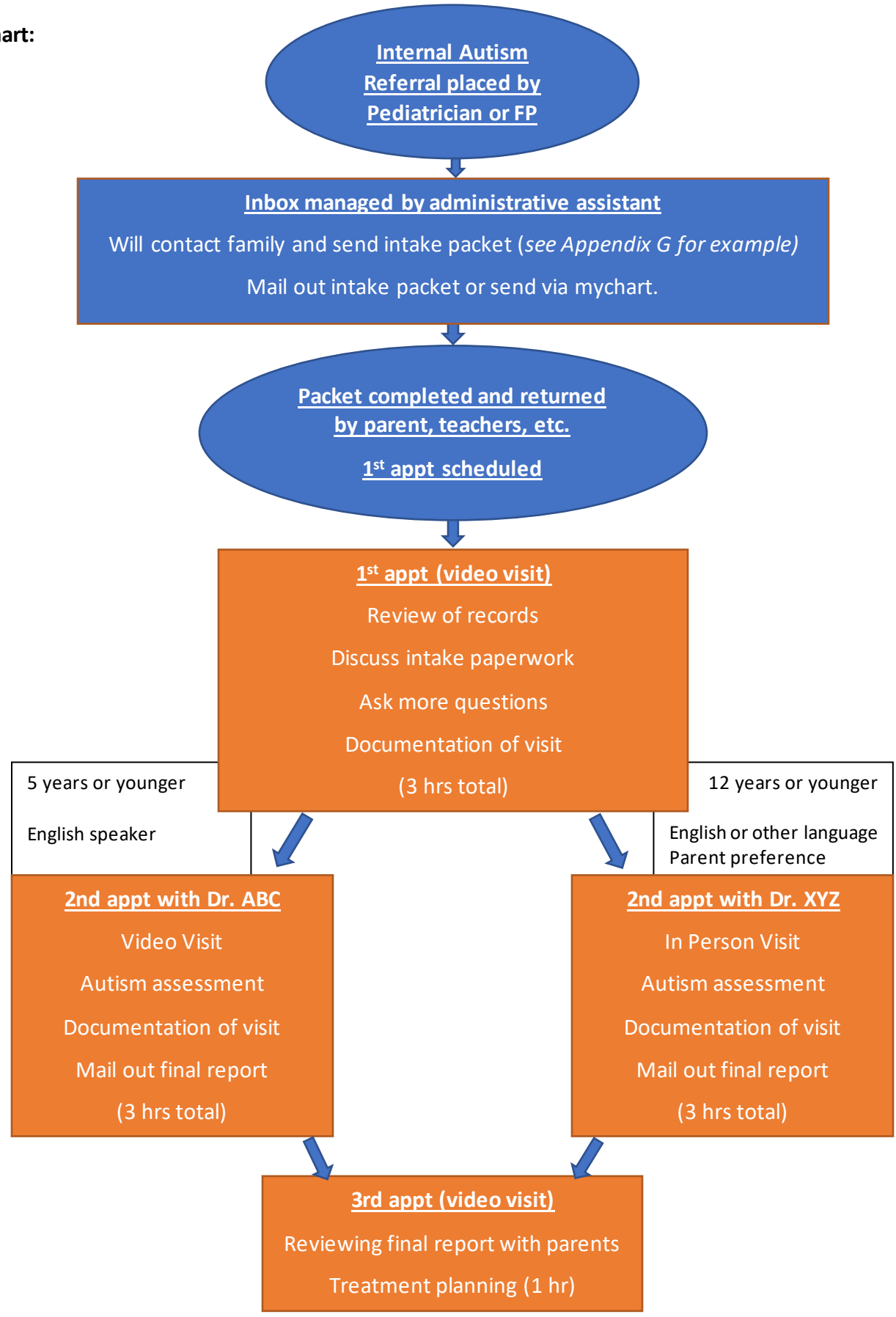
Implementation of a COMPANY NAME based Autism Clinic is a vital service to the community at large and would open up care to a highly under-served group of families and patients who routinely wait up to 2 years to be seen for initial evaluations. Early diagnosis and treatment of children with autism is imperative and greatly affects long term outcomes.

The above model provides consistent care across Optum providers, is cost effective and scalable for future expansion. We have experienced ASD providers already trained and ready to continue this work with the support of COMPANY NAME.

We urge COMPANY NAME to support this proposal, expedite the review of this project, and approve it so this important work can start again as soon as possible. LIST PROVIDER NAMES HERE are passionate about this work, are committed to seeing it succeed and eager to help other COMPANY NAME providers expand into this work in the future. Let's do the right thing! Thank you.

(Thank you to Jim Troutman, MD, and Susana Myers, DO, for sharing this template.)

Flow Chart:


Internal Autism Referral placed by Pediatrician or FP
Inbox managed by administrative assistant
Will contact family and send intake packet (see Appendix G for example)
Mail out intake packet or send via mychart.
Packet completed and returned by parent, teachers, etc.
1st appt scheduled
1st appt (video visit)
Review of records
Discuss intake paperwork
Ask more questions
Documentation of visit
(3 hrs total)
5 years or younger
English speaker
12 years or younger
English or other language
Parent preference
2nd appt with Dr. ABC
Video Visit
Autism assessment
Documentation of visit
Mail out final report
(3 hrs total)
2nd appt with Dr. XYZ
In Person Visit
Autism assessment
Documentation of visit
Mail out final report
(3 hrs total)
3rd appt (video visit)
Reviewing final report with parents
Treatment planning (1 hr)

Appendix B. COE Provider Presentations at Autism COE Trainings

(revised 5/9/2025; see Community COE Presentations Google Drive folder for presentations and handouts)

Date	COE Name/Affiliation & presentation	Clinic type	County	Other Handouts
5/16/25	**Rose Ann V Rayos, MD, FAAP,** Mason Health **Utilizing Autism Center of Excellence Program in Mason County**	Public Hospital District & SMART partnership	Mason	• What is Autism Brochure (Spanish and English) • Accessing SMART brochure • Intake packet (Spanish and English)
12/6/24 & 1/31/25	**Elizabeth Boland, MSN, ARNP, CPNP-PC, PMHNP-BC,** Yakima Velley Farm Workers Clinic **Autism Center of Excellence Program in Community Health Primary Care**	Federally Qualified Health Center (FQHC)	Yakima	• Autism Spectrum Disorder Information and Resources for Walla Walla Region
9/13/24	**Mark Fishaut, MD FAAP,** Friday Harbor Family Clinic **The Hero's Journey**	Pediatric Primary Care	San Juan	None
2/2/24	**Daniel Delgado, MD,** HealthPoint Community Center - Auburn **What I Wish I Knew When I Started My ASD COE Journey**	Community Health Center (CHC) / FQHC	King	None
9/29/23	**Patricia Scott, MD** and **Thanh Kirkpatrick, MD,** HopeCentral and Vietnamese Family Advisory Board **Supporting Autism in the Community: A Collaborative Approach**	Pediatric Primary Care & Behavioral Health	King	None
3/3/23	**Kathleen Johnson,** DNP, FNP-BC, C-PMHS, PMHNP-BE Yellow Brick Clinic **Yellow Brick Clinic: Following Our Yellow Brick Road Integrating the Autism COE with Specialty Community Practice**	Specialty Community Practice	King & tele to whole state	None
12/9/22	**Emily Bianconi,** ARNP, Skagit Pediatrics **Developing a COE Practice in Primary Care Pediatrics**	Mid-size Private Pediatric practice	Skagit	• EMR Full Autism template • Sample Autism Visit Note
9/23/22	**Vanessa Frank,** DNP, ARNP Columbia Basin Health Association (CBHA) **Incorporating COE Work Into a Federally Qualified Health Center with Migrant Farmworkers**	FQHC	Adams	• CBHA Autism Intake Form • Visit Template 2020 CBHA • CBHA Autism Toolkit • CBHA Autism Toolkit in Spanish

1/28/22	**Kristi Rice,** MD, FAAP Providence Pediatrics - Northpointe **How to Incorporate Autism Evaluation in a Busy Pediatric Practice**	Large private practice	Spokane	• Autism Intake Questionnaire
12/10/22	**Christina Pease,** MD, FAAP Sea Mar Community Health Centers **Addressing Health Inequities with an Autism Diagnosis**	FQHC	King	• El Autismo (*from the SCH 101 Autism in Spanish video done by Dr. Pease and partners)* • Entrevista con los Padres acerca del Autismo- Version Clinica en Espanol *(translation Stone 2002)*
9/24/21	**Jim Troutman**, MD, FAAP Everett Clinic **What I wish I had Known and What I Have Learned on My Journey So Far**	Large private practice	Snohomish	• Welcome letter Everett Clinic Autism Center • The Everett Clinic- Autism Eval- Teacher Interview Form • Social Communication Observation Tool e form 2017 • Preparing for your child's telehealth visit_ Clinician- VUMC • New patient intake packet 2020 • Everett Clinic Autism Evaluation form • DSM-5 Diagnostic Checklist • Dr. Cheek 5 y.o. ASD Report example • Dr. Cheek 2 y.o. ASD Report example • Child Cambridge University Behavior and Personality Questionnaire • 2-Tele-ASD-PEDS Administration guidelines
5/14/21	**Heather Buzbee**, MSN, CPNP- PC, PMHNP-BC Psych and Ped ARNP Sea Mar Federal Way **Applying the Autism COE to the Community Health Primary Care Setting**	FQHC	King	None
2/12/21	**Liz Vossenkemper**, MSN, RN, CPNP-PC, Tri-Cities Community Health **Building an Autism COE in Primary Care: Choose Your Own Adventure**	FQHC	Benton	None

9/18/20	**Julie Cheek**, MD, FAAP PeaceHealth **Neurodevelopmental and Autism Evaluations in Primary Care Practice (Cheek)** **Monica Burke**, PhD, Arc of Whatcom and SMART team lead **Collaborating to Support a County Center of Excellence for Autism Evaluation and Diagnosis (Burke)**	Large private practice Parent Support and Advocacy	Whatcom	<u>Cheek Handouts</u>: • Visit Template • New Patient intake packet 2020 Cheek • Neurodev and Autism Screening in Primary Care • NDClinic appointment checklist • NDC new patient history form • Letter apt reminder • Developmental Clinic Appointment process • Dev CI FOLLOWUP Appt Check list <u>Burke Handouts:</u> • DDA Overview + How to Apply 2020 • Community Services for CSHCN 2020 • Communication – to School from Provider e form • Communication – to School from Family e-form • Communication- to PCP e-form • Autism Services 2019 • Autism – Could it Be – 1019 • ABA Provider Matrix 2020 • ABA Intake Form Fillable 2020
7/31/20	**Bill Cheney**, M.Ed **Rick Levine**, MD, FAAP Skagit Pediatrics **A Community COE Perspective: Skagit County** (no PPT)	School District Mid-Sized Private Pediatric Practice	Skagit	• Skagit COE Process Flowchart • COE Evaluation: Early Intervention Provider Summary Evaluation Information

Appendix C. Washington State and Other Resources

Here are common resources and information shared after an autism diagnosis. You can find more information and handouts on the COE Autism Resources google drive; however, we encourage you to refer families to the Seattle Children's Autism Center's Patient and Family Education website for more organized, in-depth, and up to date info!

**Resources are available in Spanish or another language as indicated.*

General autism information

- **Autistic Self-Advocacy Network** (https://autisticadvocacy.org/book/welcome-to-the-autistic-community/): welcome packet written by autistic people for newly diagnosed individuals or those wanting to learn more.
- ***Autistic Women & Nonbinary Network** (https://awnnetwork.org/resource-library/, also in Spanish): welcome for newly diagnosed individuals as well as families, focusing on women, gender diverse, non-binary individuals.
- ***Autism Speaks First 100 Days Kit** (https://www.autismspeaks.org/tool-kit/100-day-kit-young-children; also in Spanish): steps for families with newly diagnosed children, including steps for what to do following a diagnosis.
- ***Centers for Disease Control and Prevention** (CDC; www.cdc.gov/ncbddd/autism/index.html; also in Spanish): information and videos about what autism is and how it is treated.
- **On-Time Autism Intervention** (OTAI; https://ontimeautism.org/) guidance, tools, and resources for anyone involved in supporting young children with autism.
- ***Seattle Children's Autism Center** (https://www.seattlechildrens.org/clinics/autism-center/patient-family-resources/; specific Spanish-language section and specific handouts offered in various languages) has a range of topics to help understand child development, access resources, locate services, and to participate in treatment.
- **University of Washington Autism Center** (https://depts.washington.edu/uwautism/) provides information on resources and free webinars for parents on a variety of topics such as neurodiversity, ABA, and education.
- **AS360** (https://www.as360.org/) is a platform designed for individuals in Washington state to share access to ASD providers, resources, information, and community.

State resources and information:

- **Ben's Fund** (https://www.bensfund.org/) provides families of eligible Autistic individuals (25 or younger, WA state resident) with grants (up to $1000/year) for therapeutic services, support, or equipment.
- **Department of Vocational Rehab** (DVR; www.dshs.wa.gov/dvr) assists individuals with disabilities in obtaining and maintaining employment, as well as high school transition support.
- **Developmental Disability Administration** (DDA; https://www.dshs.wa.gov/dda) assists individuals with developmental disabilities and their families to obtain services and supports (e.g., case management, respite, caregiver support, assistive technology, employment and day program services, etc.).
- **Developmental Disability Council** (DDC; https://www.ddc.wa.gov/) collaborates with other agencies and organizations, trains leaders and advocates, and advocates for better policies, programs, and practices.
- ***Help Me Grow Washington** (https://helpmegrowwa.org/; Spanish-language and interpreter supports available) provides support accessing state services (e.g., early intervention, food stamps, parenting, transportation, health insurance, etc). Families can call 1(800) 322-2588 for help.
- **Hopelink** (www.hopelink.org) support with transportation, gas cards and translation services.
- ***Informing Families** (https://informingfamilies.org/; built-in translation): statewide resource with regional contacts for information on developmental disabilities and the systems that can provide support, including age-based toolkits reviewing services/systems across the lifespan and how to apply for DDA and SSI.
- ***Miss Shayla's List** (https://medicalhome.org/quick-key-resources/shaylas-list-family-support/; also in Spanish) is a list of key financial, transportation and recreation resources to support people with IDD and their families.
- ***Supplemental Security Income** (SSI; https://www.ssa.gov/ssi/eligibility); also in Spanish) provides financial support for low-income individuals with disabilities and their families.
- **WA State Health Care Authority** (HCA; https://www.hca.wa.gov/) maintains a list of WA COE Providers by region (https://www.hca.wa.gov/assets/billers-and-providers/index-coe-applied-behavioral-analysis.pdf).

- ***Washington Mental Health Referral Service for Children and Teens** (https://www.seattlechildrens.org/clinics/washington-mental-health-referral-service/; multiple languages) connects families with mental health services in their area who fit their child's specialty needs and insurance coverage. They can also help families find an ABA provider or an autism COE provider.
- **Washington State Medical Home Partnerships Project** (WA MHPP; https://medicalhome.org/) helps health care providers, families, and communities work together to improve care for children, particularly those with special health care needs, and their families. Information about COE trainings and SMART teams is found here.

General family education, support, and advocacy

- ***Arc of Washington** (https://arcwa.org/; built-in translation) helps parents navigate the maze of special education and connect with other families through their **Parent-to- Parent program** (https://arcwa.org/parent-to-parent-2/#top; also in Spanish). There are specific coordinators for different regions of the state.
- ***Developmental Disability Ombuds** (https://ddombuds.org/; built-in translation): is a state-wide independent program to investigate, advocate, and report on services to people with developmental disabilities.
- **Partnership for Action. Voices for Empowerment** (PAVE**;** https://wapave.org/; multiple languages): learn more about special education, find local resources, and connect with others who have children with disabilities.
- **SibShops** (https://www.seattlechildrens.org/health-safety/classes-events/sibling-special-needs-sibshops/): interactive workshop for siblings (ages 6-9 or 10-13) of children with special needs.
- **Washington Autism Alliance** (WAA; https://washingtonautismalliance.org/) works to expand access to healthcare, education and community for people with autism and their parents. They also provide information and support for families who are seeking ABA therapy and struggling with insurance coverage for services.
- **Office of the Education Ombuds** (https://www.oeo.wa.gov/en) works with families and schools to address problems together so that every student can fully participate and thrive in Washington's K-12 public schools.

Self-directed comprehensive online learning programs for families

†Free program

- ***†ADEPT** (health.ucdavis.edu/mindinstitute/centers/cedd/adept.html): interactive, self-paced, online learning module providing parents with tools and training to more effectively teach their child with autism and other related neurodevelopmental disorders functional skills using applied behavior analysis (ABA) techniques.
- ***†Everyday Parenting: The ABCs of Child Rearing** (https://www.coursera.org/learn/everyday-parenting)**:** provides a toolkit of strategies and step-by-step instructions to change behaviors for both children and teens.
- ***†First Approach Skills Training** (FAST; https://www.seattlechildrens.org/healthcare-professionals/community-providers/fast/parents-caregivers/): Handouts, workbooks and other resources for evidence-based strategies across different areas including anxiety, behavior, depression, early childhood, and trauma.
- †**Help is in your Hands** (https://helpisinyourhands.org/course): made for parents to teach them more strategies such as these to build social communication skills and engagement for young children.
- **Collaborative and Proactive Solutions** (https://cpsconnection.com/training-for-parents/): Rather than focusing on kids' concerning behaviors (and modifying them), CPS helps kids and caregivers solve the problems that are causing those behaviors. The problem solving is collaborative (not unilateral) and proactive (not reactive).
- **Essentials of Parenting** (https://helpingfamiliesthrive.com/courses/parenting-essentials/; discount code "Seattle Children's"): provides education, interactive workbook and activities, and demonstrations of real families using skills to improve emotional and behavioral outcomes and family relationships for kids ages 2-12.
- **Hanen Program** (https://www.hanen.org/Programs/For-Parents.aspx): provides families of children at different developmental levels with research informed strategies for supporting language and social communication skills.
- ***Triple P** (https://www.triplep-parenting.com/us/triple-p/): an online self-guided version of an evidence-based intervention for parents to address behavioral and emotional concerns for their child age 0-16.

Family education, support, and advocacy for specific populations

- ***Chinese Autism Resources and Empowerment Services (CARES**; www.caresseattle.org; also in Mandarin Chinese) is a non-profit organization that provides community-based neurodiversity-affirming resources, online webinars, and parent training in different topics in Mandarin Chinese as well as inclusive events.

- ***Dads MOVE** (https://www.dadsmove.org/; built-in translation) provides support, training and advocacy for parents/caregivers, especially dads, who have children and youth with behavioral challenges.
- **Families of Color Seattle** (https://www.focseattle.org/) connects families, caregivers, and children of color through peer-led parent support groups; spaces to share culture, skills, and resources; and racial justice education and advocacy.
- **Joint Base Lewis-McChord (JBLM) Autism Center** (www.operationautism.org/base-post/joint-base-lewis-mcchord/): Military families may wish to contact the JBLM Autism Center called Operation Autism, for local support and resources for military families.
- ***Lewis County Autism Coalition Entendiendo El Autismo** (https://www.lcautism.org/lewis-county-autism-coalition-entendiendo-el-autismo) provides family support, training, and resource for Hispanic families.
- ***Manos Unidos International** (https://www.manosunidasinternational.org/families/; also in Spanish) offers training, consultation, and advocacy support to individuals with disabilities and their families.
- ***Open Doors for Multicultural Families** (https://opendoorswa.org/; built-in translation) provides a variety of supports to families in King county by matching them with a staff member who shares their background.
- **Parenting Without Pity** (https://rootedinrights.org/stories/collections/parenting-without-pity/) shares a series of stories told by disabled parents about their experiences to inform parents of disabled people.
- **Somali Health Board** (https://somalihealthboard.org/) works to address health disparities disproportionately affecting new immigrants and refugees within King County, including the underdiagnosis of autism and other developmental disabilities through community events, workshops, and family support.
- **Square Pegs Adult Autistic Meetup Group** (https://www.meetup.com/Squarepegs/; built-in translation) is a place for adults on any part of the spectrum, diagnosed, self-diagnosed, or questioning to get to know one another and make new friends without having to explain our eccentricities.
- ***Vietnamese Family Autism Advisory Board** (VFAAB; https://vfaab.org/; also in Vietnamese) resource to Vietnamese families, assisting people with navigating the care system to connect to support services and educating the community about autism and developmental delay.
- **WA Multicultural Link** (www.wmslink.org) provides support services to African Diaspora and African American families, especially individuals with disabilities, and health care needs.
- **Washington State Fathers Network** (https://fathersnetwork.org/) connects fathers and families of children with a disability or special health care need with each other and with resources and information, by training men to tell their story and advocate for change, and by working to promote inclusion.

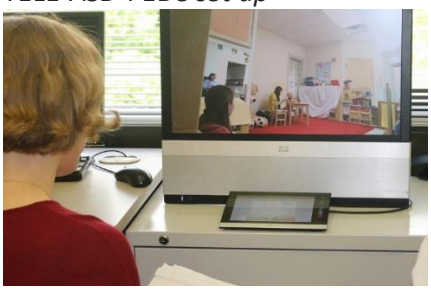
Safety and crisis care

- **Big Red Safety Box** (https://nationalautismassociation.org/big-red-safety-box/) offers downloadable information about resources to help caregivers prevent and respond to wandering incidents. They also offer a free safety kit to families when supplies allow.
- **Disability Parking Permits** (https://www.dol.wa.gov/driver-licenses-and-permits/get-or-renew-disabled-parking-permits) may be available for individuals with disabilities who are not able to safely walk independently due to behaviors like wandering and elopement.
- ***Smart 911** (https://www.smart911.com/; built-in translation) is a free service that allows families to provide information about their household, such as having a child with autism or other developmental disabilities, to 911 in case of emergencies.
- **Seattle Children's Psychiatric Urgent Care** (https://www.seattlechildrens.org/clinics/psychiatry-and-behavioral-medicine/psychiatric-urgent-care/): Offers same day in person or virtual visits for urgent mental and behavioral health concerns not needing the care of an emergency department (serves youth ages 4 through 17).
- **Washington State Mental and Behavioral Health Crisis Information** (https://www.hca.wa.gov/free-or-low-cost-health-care/i-need-behavioral-health-support/mental-health-crisis-lines): provides information on how to access crisis lines, as well as what to expect when you call them.

Appendix D. Evaluation set up tips, toys, and observation examples

For **young children**, consider using a tool or toys specifically designed to elicit social communication and play behaviors in toddlers. The STAT or RITA-T are tools that can be used to facilitate an interaction between the provider and the child with a specific set of toys to identify *risk* for autism. The ASD-PEDS is a similar free semi-structured interaction protocol, which can also be administered via telehealth with the caregiver and child (TELE-ASD-PEDS); it includes a training manual, script and scoring form, as well as additional supports for conducting telehealth assessments, such as videos for caregivers, how to set up the room, and suggested materials.

TELE-ASD-PEDS set up



STAT administration materials

For **older children**, the most comprehensive formal assessment tool is the ADOS-2 (Autism Diagnostic Observation Schedule, Second Edition). The ADOS-2 was specifically designed to provide a thorough assessment of behaviors through a variety of specific prompts that vary by age and language level. However, this may not be the most accessible option for your practice given the costs, training, and time required to administer it.

ADOS-2 materials kit

(As a reminder, diagnostic tools are proprietary, meaning that you are not able to use the protocols or materials without purchasing them from the publisher and completing any required training.)

While the ADOS-2 is helpful, it's not required! You can still conduct evaluations with older children and teens using other tools. Consider what age-appropriate toys and activities can provide you with opportunities to observe various social communication and behaviors associated with autism. To do this, you need to be aware of how autism presents differently across the lifespan (review *Box 3* of the NICE guidance summary for potential signs of autism in older children and teens). For older and/or more verbal individuals, you also need to consider conversation starters and questions about social interactions, friends, interests, and experiences (see Table 2 of this article *Understanding the social experiences of adolescent females on the autism spectrum* for example questions you could ask).

The *ASD Diagnostic Guidance Documents* from HollandBloorview provides a detailed summary of symptoms, activities, and questions that can guide your assessment for younger (Toddler/Preschool) and older (Older/School Age) individuals. You might also find this summary of DSM-5 ASD behavioral examples compiled by a member of the CDC Autism and Developmental Disabilities Monitoring (ADDM) project to be helpful in interpreting behaviors according to the DSM-5.

The following page has potential additional activities to incorporate into your visits.

[*Thank you to the following providers who shared their ideas to add to this list: Karís Casagrande, PhD (Seattle Children's Autism Center), Julie Cheek MD FAAP (PeaceHealth), Vanessa Frank, DNP, ARNP (Columbia Basin Health Association), Jennifer Gerdts, PhD (Seattle Children's Autism Center), Christina Pease, MD FAAP (SeaMar Medical Clinic), Jennifer Mannheim, ARNP (Seattle Children's Autism Center), and Emily Myers, MD, FAAP DBP (University of Washington and Seattle Children's).*]

Below are potential toys and activities, with behaviors to observe for each. *(You might use bins to keep toys for younger and older children separate, as well as make sure those toys do not wind up in the waiting room or other clinic spaces.)*

Toys	Observation tips
Cars and trains with tracks *(Consider having extra pieces such as a garage, ramps, tracks, road signs, etc. that can be used with them)*	Keeping these high value items in **clear, hard to open containers** is a great way to see how an individual directs attention to the objects and requests help. **Watch how they play** with the toys. For example, are they engaging in **functional** (e.g., driving cars, pushing trains)/**pretend** play (e.g., making up/ acting out a story) or **sensory/repetitive** play (e.g., visual inspection, lining them up, spinning the wheels, sorting by color)?
Plastic figurines, dolls, and pretend play toys (e.g., kitchen, tea set, dollhouse) *(Consider small and large figurines such as people, animals, dinosaurs, and insects that appeal to a range of ages)*	Look for developmentally appropriate **pretend play**. For example, how are they using the dolls or figurines in their play? Younger children may direct their actions to the figurine (e.g., feeding the doll), while older children may have the figurines interact with each other by talking to each other. See whether they are willing to **follow your lead** in pretend play or interactive activity with these toys, or if they are **resistant** to you changing their play.
Building materials like blocks, LEGO, or magnetic tiles *(Consider having large blocks, like DUPLOs for fine motor or mouthing concerns, as well as regular LEGO or building blocks. Magnetic tiles are another option that are easy to clean.)*	Watch for any **repetitive patterns or themes** in what they choose to build. One way to check for this is to see if the individual is **flexible** about following your lead in what to build, or whether they will allow you to change what they have built by adding to it or doing it differently. Keep some of the pieces separate and **watch how they request** additional blocks when needed. You can also see whether they share their creations with others by directing excitement or frustration.
Cause-and-effect toys with lights and sounds *(Examples are pop-up toys, electronic musical toys, jack in the box, etc).*	Many children engage in some repetitive play with toys like these, but you can watch whether they follow a **specific pattern** with the buttons they push, or focus in on one specific repetitive action instead of varying their use. See how an individual **reacts** when you attempt to take turns, turn off the lights or sound, block their ability to push buttons, or remove it from the room.
Puzzles, shape sorters, letter/ number magnets, etc.	**Set aside some of the pieces** so that they are unable to get them on their own. How do they react when a piece is missing? How do they manage frustration? What is their approach for problem solving?
Books, magazines, crayons, paper, coloring books *(Make sure to have a range that would appeal to a range of ages and interests!)*	Watch whether the individual **attempts to share** interest or excitement in a book or a drawing with others in the room. Do they invite their parent to color with them or show off something that they have made? When they see something interesting in the book, do they look around the room to check in? Use books or magazines as **conversation starters**. For example, do individuals respond to your non-directed comments and interests? During conversations, are they able to switch topics away from their interests to follow yours?
Sensory play activities like bubbles, playdoh, water, lights, and mirrors *(Make sure you have a way to contain the mess! Bubble machines are great.)*	Watch for **repetitive movements, sensory seeking, or sensory aversions**. For example, when excited about bubbles or lights do they flap, spin, or posture? Do they have a negative reaction to the feeling or bubble liquid or playdoh? Or seek out additional sensory input by licking or smelling the materials?
Art, pictures, or stickers on walls	Point to or comment on them. How do they react or shares engagement?
Floor mats (e.g., foam puzzle mats or gymnastic mats)	Padded puzzle mats or foldable gymnastic mats are a colorful and easy to clean way to set up play materials on the floor for younger children!

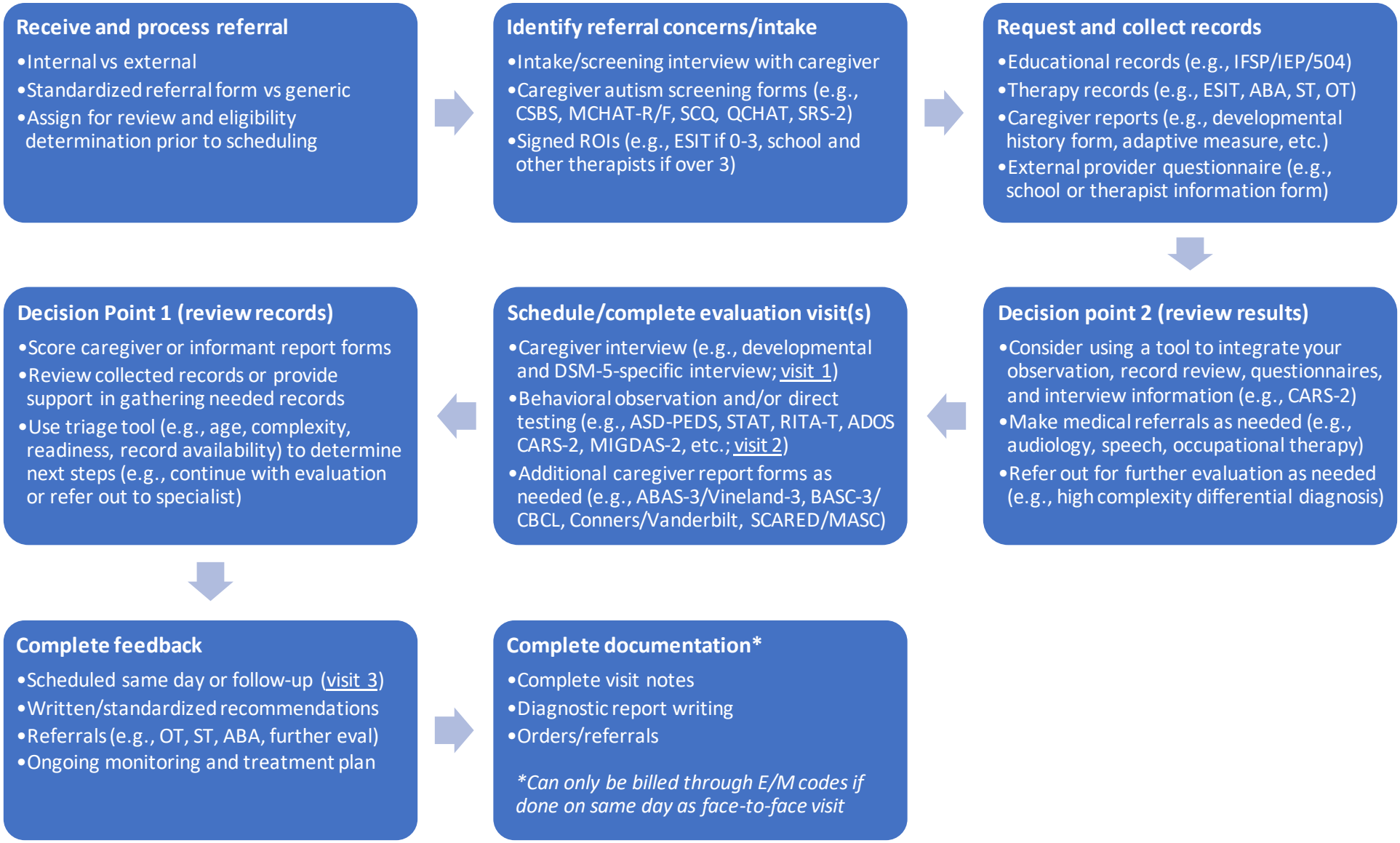
Appendix E. Evaluation Models and Workflows

Overview of Evaluation Model Types

Model Type	Single Discipline	Multidisciplinary	Interdisciplinary
Summary	A single provider completes all components of the evaluation	Each discipline completes a discipline specific assessment, and may make separate diagnoses and recommendations	Team members complete various parts of the evaluation, and make the final diagnosis and recommendations in collaboration
Examples	A private practice psychologist	Primary care provider referring to a speech language pathologist or school for additional developmental assessment; School-Medical Autism Review Team (SMART)	Tertiary care centers like Seattle Children's Autism Center
Possible Visit flow	*(Visits completed/billed by psychologist)* Visit 1: Intake (60 min, 90791) Visit 2: ASD interview and developmental testing (90-120 min, 96112/13, 90630/31) Visit 3: Other cognitive or psychological testing (60-120 min, 96112/3, 96137/38, 96130/31) Visit 4: Feedback (60 min, 96130/31) **Codes bundled for billing, including all testing and documentation time*	*(Visits completed/billed by MD or APP)* Visit 1: Intake (30 min, E/M time-based codes) *Request/review records, refer for IEP, speech, audiology evaluation as needed* Visit 2/3: Autism interview and observation (30-60 min each, E/M codes) *Review external evaluations and integrate* Visit 4: Feedback (30 minutes, E/M codes) **Codes billed on visit date, can only capture record review/documentation if same day*	*(Visits completed/billed by psychologist + APP)* Visit 1: Intake (60-120 minutes, APP E/M time-based codes, PhD/PsyD 90791) Visit 2: Team evaluation. Partner 1 completes interview. Partner 2 completes ADOS. Partner 1 and 2 discuss findings. Partner 1 or 2 completes feedback and full report. (4 hours total; APP bills E/M codes, PhD/PsyD bills 96113/3, 96130/31). **Mix of CPT and E/M codes billed based on provider type for each visit separately*
Additional details	• Single discipline models vary in depth and breadth of evaluation • Can be multiple visits with psychologist with a comprehensive neuropsychological battery • Can be medical-based model with medical providers (who may request supplementary assessments to gain information –see multi-disciplinary evaluation model)	• Can begin as a single discipline assessment with initial screening or assessment, but additional information is needed before a diagnostic decision is made • Referral is made for further evaluation or data collection to another provider (e.g., SLP, EI team, OT, school psychologist) • Individual reports are compiled, rather than integrated, with minimal to no collaboration between team members	• Process is more streamlined and direct than a multidisciplinary assessment, but also requires greater coordination and staffing to complete as it is a complex model • Team members may see the patient in tandem or on different days, but the key component is that these teams discuss the patient together and write a single report • Findings and recommendations from each team member are fully integrated

**See Appendix K. Suggested Billing and Diagnosis Codes for COEs & SMART Teams for more details about billing codes.*

General Workflow Process Components



See Appendix K. Suggested Billing and Diagnosis Codes for COEs & SMART Teams for more details about billing codes.

Primary Care COE Workflow Example

(From 12/6/2024 COE training presentation by Elizabeth Boland, ARNP: see *Community COE Presentations* Google Drive folder)

PCP identifies concerns and makes a referral	Initial 15min "Meet and Greet"	Send Intake Letters (pre-prepared at nursing station)	Prepare for Evaluation
•Internal referrals only •Referring provider sends patient's chart via EPIC care coordination message •Patient schedules 15min 'meet and greet' with COE provider to discuss development specifically •If concerns are for COE provider's primary care patient, schedule a separate 15 minute meeting to discuss specific concerns as well	•Discuss preliminary concerns about development, behavior, etc. •Complete screening forms (e.g., M-CHAT, CAST, AQ) if not already done •Review the COE process •Refer to nursing for completion of ROIs and to provide ASD COE intake packet •Refer to audiology if not already done •Refer for dev peds evaluation as needed	•2 packets (18m-5yrs and 6yrs+, available in English and Spanish, multiple form copies as needed) •Parent letter •Patient history form •Teacher history form *(older only)* •ROIs for childcare/ESIT/school •Questionnaires •ASQ/ASQ-SE *(younger only)* •Vanderbilt ADHD *(preschool <5 or standard 5+ version)* •CBCL *(Parent + teacher report)* •SCQ, and CASD *(older only)*	•Review intake packet and score completed forms •Review IEPs for cognitive, speech, and adaptive testing as available •Refer to colleague for ADOS as available •Schedule 3 evaluation visits (as seen below)

Visit 1: Screening
- DSM-5 structured interview
- Review completed history and screening forms (before/after visit)

Visit 2: Evaluation
- Under 48 months: Screening tool for Autism in Toddlers (STAT)
- Over 48 months: Autism Mental Status Exam (AMSE)

Visit 3: Summary/Feedback
- Summarize findings (DSM-5 checklist)
- Provide resources and referrals
- ABA RX, school letter, CYSCHN for DDA as needed
- Schedule 4-6 week follow-up

** All evaluation visits are billed using E/M codes and scheduled for 30 minutes, often right before the lunch break or at the end of day to allow for more time*

Multidisciplinary SMART Workflow Example

(From 5/16/2025 COE training presentation by Rose Rayos, MD FAAP: see *Community COE Presentations* Google Drive folder)

PCP identifies concerns and makes a referral

- Referral to Mason County School and Medical Autism Review Team (SMART)
- Regional referrals accepted (with insurance preauthorization)
- Serves patients aged 18 months to 17 years old
- Patient completes an intake packet prior to their first appointment

Intake packet completed by caregiver

- English and Spanish packets
- Introduction letter with overview of evaluation process and checklist
- Demographics and services form
- Release of information to allow communication between COE and School
- SMART social communication and behavioral observation report tool
- Teacher interview form
- List of outside records to collect (e.g., report cards, IEP/50 and evaluation summary, other evaluations)

Monthly SMART Meetings

- Multidisciplinary meeting to discuss active SMART evaluation patients
- Patients discussed after initial COE visit, but before final feedback
- Includes COE and SLP/OT evaluation partners, MHPP coordinator, and representatives from the School, CYSHCN, ESIT, Developmental Preschool, and ESD113.
- Collaborate on diagnostic decision making and recommendations

Visit 1: COE Interview

1. General medical developmental interview and review of symptoms
2. DSM-5 ASD structured interview:
   - For Toddler: Toddler Medical and Developmental Interview
   - For School Age: OHSU Interview
3. Compete ASD Symptom Checklist and Confidence Rating Scale
4. Make referral to Mason Health Rehab for Visit 2 evaluation

Visit 2: SLP or OT evaluation

Administration of structured tools like:

- ADOS-2
- CARS-2
- Sensory Profile
- STAT

Visit 3: Summary/Feedback

Share final copy of report with patient, school, and PCP

If diagnosed with autism*, include the following:

- Regional info (i.e., Mason County What is Autism? and Local Resource Guide)
- ABA, ST, OT, diapers, parking permit prescriptions as appropriate
- Local CYSHCN coordinator for DDA/SSI application support
- Autism education materials (e.g., ADEPT, First Steps, Autism 101)
- Mental health (e.g., crisis plan, referral to psychiatry)
- Other relevant resources (e.g., SPARK for genetics testing, Ben's fund for financial support, Autism Speaks for general autism information, etc)

If child is NOT diagnosed with autism, tailor recommendations to their individual needs and state that child **doesn't meet criteria at this time; however **future reevaluations can be requested** when child is older and if more concerns arise*

Additional Workflow Examples for Different Provider Types

	Example A – APP	Model B – MD or PMHNP	Model C – MD/PhD or PsyD	Model D – MD/APP
Intake/Pre-work *Process referral* *Review concerns* *Determine eligibility* *Request records*	**Internal referrals only** *(PCP sends chart/concern)* **Review/request records** (10-30 min) **Eligibility check** *(need to have IEP/IFSP testing; no Tricare; any age accepted, but may refer out based on complexity using triage tool)*	**Internal referrals only** *(PCP uses ASD referral form)* **Review/request records** (10-30 min) **Eligibility check** *(no Tricare; any age accepted, but may refer out based on complexity using triage tool)* **Refer** for IEP, audiology, lead screening as needed	**Internal or external referrals** *(no standard referral form)* **Review/request records** (10-30 min) **Scheduled** based on age *(under 3 w/ MD, over 3 w/ PhD or PsyD)*	**Internal referrals only** *(ages < 9 only)* **Structured clinical intake packet** mailed to family by an RN *(ROIs, caregiver history, autism screening forms like the CAST or ASSQ, and other questionnaires like Vanderbilt)* **Review/request records** (20-30 min)
Interview and Observation *DSM ASD + med/dev interview* *ASD behavioral observation* *Refer for/ complete additional testing as needed*	**Visit 1: Parent interview** w/ brief child observation (60 min.) **Request records** *(caregiver/ teacher/ other questionnaires; IEP/IFSP if not already obtained)* **Make referrals** to speech or audiology as needed *(can also refer out to EI or private SLP for STAT or ADOS)*	**Age-based tracks** for under 6 (w/ MD) and over 6 (w/ PMHNP) **Visit 1: Screening** around ASD concerns, previous evals and services (30 min) **Add'l visits (60 min each, as needed, until done)**: general and DSM-5 ASD interview; Observation (may use STAT or CARS-2); psychiatric interviewing (as needed)	**Age-based tracks** for under 3 *(w/ MD),* over 3 *(w/ PhD or Psy D)* **Visit 1: Structured parent interview** *(60 minutes)* **Visit 2: Observation** using STAT (under 3) or ADOS (over 3) *(up to 2 hrs w/ documentation)*	**Visit 1**: In depth family interview and interaction *(STAT for young patients*; 60-90 minutes); RN supports throughout as needed **Request additional records** *(caregiver/ teacher/ other questionnaires)* **Make referrals** for audiology, ST, OT, IEP evaluations as needed. **Refer out for ADOS** as needed.
Follow up work/ feedback visit *Review/ integrate records to complete assessment*	Check for received records, review, and schedule visit 2 **Visit 2: Feedback** to review findings and discuss referrals and recommendations (60 min)	Check for received records, review, and schedule visit 2 **Final Visit: Feedback** to review findings and discuss referrals and recommendations (30 min)	**Visit 3: Feedback** and treatment planning (*up to 2 hrs w/ documentation)* If internal patient, connected with CHW for follow-up support	**Visit 3: Feedback** to review findings and discuss referrals and recommendations (30 min) May refer out for ADOS or for OT/ST/IEP.
Follow-up visit	**Visit 3: 3-4 month follow-up** to check on referrals, barriers, needs (15 min)	**Refer back to PCP** for follow-up	**Visit 4: 3-4 month follow-up** to check on referrals, barriers, needs (15 min)	**Refer back to PCP** for follow-up Use Single Entry Access to Services [SEAS] for community referrals
Documentation/ Billing	45 min documentation; bill E/M codes	60 min documentation; MD bill E/M codes, PMHNP bill CPT codes	60-90 min documentation; MD bill E/M codes, PhD/PsyD bill CPT	60 min documentation; bill E/M codes
Provider	ARNP, Pediatric Primary Care (Skagit County)	MD, Pediatric Primary Care/PMHNP; Integrated Behavioral Health (King County)	MD, Pediatric Primary Care/ PhD or PsyD, Integrated Behavioral Health (King County)	ARNP and MD, general primary care (Whatcom County)

Appendix F. Buzbee Autism Primary Care Complexity Triage (APCCT) tool

<table>
<tr><th>Complexity Level</th><th>Complexity Factors (1 point for each bullet)</th></tr>
<tr><td><u>Straightforward</u>
• 18mo-5yo
• Clear presentation
• Records available
• All history congruent
• Family/CG ready to discuss ASD
• Appropriate for Primary Care Autism evaluation</td><td>• 6yo+
• 12yo+
• Female, trans, or non-binary
• Medical complexity, such as:
  ○ Multiple chronic diagnoses
  ○ Concussion
  ○ Genetic dx
• Gaps in history/limited records, such as:
  ○ Homeschooled
  ○ No hx of structured education
  ○ Foster care hx
  ○ Multiple (serial) early CG's
  ○ Adoption
  ○ Conflicting hx
• Significant Psycho-Social issues, such as:
  ○ Family resistance to evaluation
  ○ Hx of homelessness
  ○ CG language barrier
  ○ Cultural barrier (ASD- foreign concept)
  ○ CG-child conflict
  ○ CG learning disability/literacy issues
  ○ CG SUD
  ○ Hx of institutional care</td></tr>
<tr><td><u>Mild Complexity</u>
• ≤3 complexity factors
• Appropriate for Primary Care Autism evaluation at provider discretion</td><td rowspan="2"><u>Mental Health Complexity</u>
• Family hx of psychotic disorders
• 1st degree relative with psychotic disorder
• SUD
• Trauma/abuse
• PTSD dx following trauma
• Single (1st) psychiatric hospitalization
• Multiple psychiatric hospitalizations
• Hx of manic/psychotic episodes
• Reactive Attachment Disorder dx
• Multiple (>3) psych dx</td></tr>
<tr><td><u>Moderate Complexity</u>
• 4-10 complexity factors
-or-
• 3+ Mental health factors
-or-
• CG firm resistance to evaluation
• Appropriate for Autism evaluation with experienced providers at provider discretion</td></tr>
<tr><td><u>High Complexity-</u> Refer for specialty evaluation
• No developmental hx available
-or-
• 2+ Neuro factors
-or-
• 11+ complexity factors
-or-
• 5+ Mental health factors
-or-
• >17yo
-or-
• <18mo
-or-
• Tricare insurance</td><td><u>Neurological Complexity</u>
• Moderate-Severe TBI
• Memory impairment
• Active seizure disorder
• Cerebral Palsy
• Severe vision impairment
• Hearing impairment
• Other significant neurological conditions
• Fetal drug/alcohol exposure</td></tr>
</table>

CG - Caregiver, SUD- Substance Use Disorder, hx-history, dx-diagnosis (Buzbee, 2023)

Background:
In 2019, I completed the Autism Center of Excellence (COE) training through the Washington Health Care Authority, which allows community providers to diagnose autism spectrum disorder (ASD) in straightforward cases in their medical home. This allowed me to diagnose patients who sometimes had been waiting for years to see a specialist. Diagnosing autism in young children is my favorite part of my job. It is meaningful work which can have a significant impact on long-term outcomes. However, I quickly found that there is a great deal of community confusion regarding what the COE training is and which patients it is appropriate for. The situation can be summarized in four connected problems.

1. **The demand for ASD evaluations exceeds the capacity of specialists** (both in Washington and nationally), (Johnson, et al., 2023).
    a. Training primary care providers to diagnose ASD is a partial solution, but even with this system change, wait times to see specialists are excessive.
2. **Patients presenting to community Autism COE providers are often complex and exceed COE training.**
    a. The Autism COE training (~12h) does not replace the years of training that specialists go through.
    b. Most parents don't understand the difference between a COE and speciality providers, they're just looking for someone to help their child.
3. **There are significant racial and SES disparities in access to autism care in the US** (Johnson, et al., 2023)
    a. Families with literacy challenges & lack of documented developmental histories are more likely to present to community providers than specialists who have the time & assessment tools to serve complex patients.
4. **Patient/system demands that exceed provider time & resources contributes to provider burnout**
    a. I have observed many primary care COE colleagues stop providing autism evaluations or quit entirely due to burnout and patient demands far exceeding what they could manage in a work day.
    b. Most primary care COE's I know who continue to engage in this work are only able to by devoting many hours of unpaid personal time to record review and documentation. This is not a sustainable expectation.
    c. Provider burnout is a crisis in the US healthcare system which contributes to decreased health care access and increased health disparities (AAMC, 2020).

Provider burnout increases problem #1. Disorganized systems contribute to problems #2, 3 & 4. The APCCT tool is aimed at triaging patients to make systems more efficient for both patients and providers. I literally dreamed this tool up one night while working on my LEND (Leadership Education in Neurodevelopmental and related Disabilities) project and have made adjustments based on feedback from providers at Seattle Children's Autism Center, the University of Washington Institute of Human Development and Disabilities and Washington Autism COE providers.

Instructions for Use:
The APCCT tool is a triaging framework to be used at provider discretion. Individual providers have diverse experiences, training and backgrounds and should evaluate ASD as is appropriate for their individual scope, training and comfort level. This tool is meant to help sort the very complex cases who need to see specialists get on the appropriate wait-lists sooner and help schedule cases to match provider time and skill capacity. Which specialist a patient should be referred to depends on age, individual complexity factors, and available regional specialty providers. Generally, neurological factors indicate referral to neurodevelopmental or neurology clinics. Mental health factors usually indicate a need for psychiatric and/or psychology assessment. A long list of complexity factors may require a team evaluation at an autism or developmental clinic. Patients with Tri-Care insurance should contact their insurance carrier for prior authorization and list of approved providers. Adults should see providers (usually psychologists) trained in adult ASD evaluations.

Permissions for Use:
The APCCT tool is free for primary care providers and clinics to use to serve young and under-resourced patients with concerns for ASD. If you choose to modify this tool for your individual practice, please note "Adapted from APCCT, Buzbee, 2023". Anyone interested in using the APCCT for commercial or electronic use should contact heatherbuzbeepnp3@gmail.com for permission.

Heather Buzbee, MSN, CPNP-PC, PMHNP-BC, PhD-S

References:
Association of American Medical Colleges. (2020). The complexities of physician supply and demand: Projections from 2018 to 2033.
Johnson, N. L., Fial, A., Van Hecke, A. V., Whitmore, K., Meyer, K., Pena, S., Carlson, M., & Koth, K. A. (2023). A Scoping Review of Diagnosis of Autism Spectrum Disorder in Primary Care. Journal of Pediatric Health Care. https://doi.org/10.1016/j.pedhc.2023.04.003

Appendix G. Intake packet example

Thank you to Jim Troutman and Susana Myers with the Everett Clinic for sharing their intake materials. Additional intake packets and documents can be found under the COE Quick Start and Supporting Materials Google Drive folder.

CLINIC NAME Autism Center

Greetings. We are pleased to be of service to you and your child. Enclosed are materials we ask for you to fill out as completely as you can and return to us at your earliest convenience. If your child is in preschool or daycare, or receives services with a speech or occupational therapist, please have them fill out the Teacher Interview Form and return it with your other forms. Once we receive everything, we will contact you to set up an appointment for your child's Autism Evaluation with FILL IN PROVIDER'S NAMES. **Your appointment cannot be scheduled until we receive your paperwork. You can mail or fax it back. Or to speed up the process, you can drop them off at our location at the address provided on the business card**. FILL IN PROVIDER'S NAMES have combined general pediatrics experience of 40+ years and have received certification through the Washington State Autism Center of Excellence (COE).

Your child's first appointment will be done virtually. This is an intake appointment to gather more information about your child. The second appointment will include an autism evaluation tool for toddlers and young children. It can be done virtually or in person depending on their age and your preference. These appointments will last 40-60 minutes. Given the length of the appointments, it is critical that you not miss your appointment and that you are well prepared for the visit. If you are unable to keep your child's appointment due to serious personal issues, you must call at least 48 hours in advance to cancel (425-493-6002). **Any unexcused or missed appointments will result in cancellation of your child's evaluation and your child will NOT be rescheduled as we have a waiting list and you may have to seek autism services elsewhere. REVISE THIS ENTIRE SECTION TO MEET YOUR SPECIFICS**

The virtual appointment will involve review of the medical and developmental information you submitted and other specific questions that are aimed at understanding who your child is, how they play and interact with other children and adults, and what kinds of behaviors they exhibit in various situations.

At the second appointment, we will observe your child play. There will be an additional appointment after that to give you final feedback and discuss treatment planning.

We are really happy to be here to help you and your child. We know being referred for an autism evaluation can be a difficult situation to face. It is critical for you and the health care providers to understand all your child's needs and conditions as fully as possible in order for them to thrive and blossom to their full potential. Please know that we will continue to be available at later dates as a resource for you, as it relates to special needs services and help you and your primary care provider navigate the system and how to best advocate for your child. We look forward to meeting you and your child, and will work hard to schedule the appointment as soon as we possibly can.

Sincerely, Your COMPANY NAME Autism Team

Cost for Evaluation
COMPANY NAME
Autism Center

The estimated cost of our full diagnostic evaluation is approximately [FILL IN]. This includes 7 hours of the physicians' time (intake, assessment, report writing, and treatment planning) over the course of 3 appointments. You will receive an official report at the end of the evaluation.

If your insurance does not cover the entire cost of the appointment, you will be responsible for the remaining balance. EXAMPLE ONLY - DECIDE WITH YOUR FINANCE/BILLING DEPT HOW YOU WILL BILL AND HANDLE COMMERCIAL INSURANCE IF YOU ARE GOING TO ACCEPT IT

Cancellation Policy: All confirmed appointments require 24-hour advance notice for cancellation. If we do not receive at least 24-hour advance notice that you are canceling, you will be billed at the standard rate for that appointment. Exceptions may be made in the case of illness or family medical emergency. Please note that we cannot bill insurance companies for missed appointments. New clients who have not yet been seen, who "no show" for their appointment or cancel more than one appointment, will be removed from the waitlist and will not be seen.

I, the parent/legal guardian/patient understand that: (initial each box)

___ I am responsible for all charges for services provided to me and/or my child by the COMPANY NAME unless insurance exclusions apply.

___ I understand that some insurance companies do not cover some services provided and it is my responsibility to contact my insurance carrier to determine whether the services by the assigned provider will in fact be covered.

___I understand my insurance may also have a deductible component. I verify I have checked or will check with my insurance prior to the scheduled appointment to make sure I know what cost I will be responsible for if there is a deductible.

Print patient's name _____

Your signature below verifies that you have read this document, agree to its terms, and agree to pay for care received through the COMPANY NAME

_____

Signature **Date** **Printed Name**

_____

Relationship

If signed by person other than patient, please specify your relationship to patient: Parent/Guardian

Patient History for Neurodevelopmental Assessment

*(Note: You can find a **fillable PDF** version and an editable word of this history form, and other examples in the [COE Quick Start and Supporting Materials] Google Drive folder.)*

Today's date: _____

Child's name: _____ Date of birth:_____

Guardian: ☐ Both parents ☐ Mother ☐ Father ☐ DSHS ☐ Foster Parent ☐ Adoptive Other: _____

Parents: Married_____ Separated_____ Divorced_____

Current Concerns

What are your primary concerns about your child? _____

_____

When did you first have these concerns? _____

_____

Has your child had previous evaluations for these concerns and what were you told?_____

_____

What have you been told about your child's future or any diagnosis? _____

_____

Birth and Early Infancy History

Age of mother at time of birth _____ and age of father at time of birth _____

Was the pregnancy planned? ☐ Unknown ☐ No ☐ Yes

Does the mother have any history of miscarriage or still birth? _____

Any difficulty becoming pregnant? ☐ No ☐ Yes ☐ Unsure _____

Was the mother exposed to any of the following while pregnant? ☐ None ☐ Yes (check all that apply)
☐ Drugs ☐ Marijuana ☐ Alcohol ☐ Tobacco ☐ Prescription Medications ☐ X- rays

Did the mother experience any significant illness during pregnancy? ☐ Unknown ☐ No ☐ Yes
If yes, please explain: _____

Labor and Deliver: ☐ Vaginal ☐ C-section ☐ Forceps ☐ Vacuum assist ☐ Unknown

Was the delivery difficult? ☐ Unknown ☐ No ☐ Yes If yes, please explain: _____

Age in weeks at time of delivery: _____ weeks Birth Weight: _____

Were there any problems after birth? (examples: jaundice, need for oxygen, infections, feeding problems, seizures): ☐ Unknown ☐ No ☐ Yes If yes, please explain: _____

_____

Were there any difficulties during infancy? (examples: excessive crying, vomiting, "colic", poor feeding, sleep difficulty):
☐ Unknown ☐ No ☐ Yes If yes, please explain:_____

Birth Order: 1st 2nd 3rd 4th ____ child

Age first sat: ____ Age first crawled: ____ Age first walked: _____

Age first word: _____ Age first 2-word phrase: _____

Age first pointed: ____ Age first smile:____

Head circumference size **normal?**: Yes____ No____ (please explain) _____

Medical and Physical History

Does your child have any allergies? ☐ No ☐ Yes ☐ Unsure _____

Is your child having any sleep issues? ☐ No ☐ Yes: ☐ Restless ☐ Snoring ☐ Pauses ☐ Night awakenings

☐ Difficulty falling asleep ☐ Sleep walking ☐ Other: _____

Does your child have any feeding issues? ☐ No ☐ Yes: ☐ Gagging ☐ Vomiting ☐ Underweight ☐ Overweight

☐ Feeding self ☐ Picky eater ☐ Sitting still for a meal ☐ Other: _____

What type of food does your child eat? ☐ Formula ☐ Pureed ☐ Finely Chopped ☐ Regular

Problems with Toileting: Constipation soiling, Bladder control, Bedwetting (please circle) ? ☐ No ☐ Yes

Toilet trained at what age _____

Has your child had their hearing tested? ☐ No ☐ Yes Location: _____ date: _____

Has your child had their vision tested? ☐ No ☐ Yes Location: _____ date: _____

Does your child have any history of hospitalizations, surgeries, serious accidents, head injury or concussion, serious or chronic illness? ☐ No ☐ Yes: _____

_____

Does your child have any pain issues or concerns? ☐ No ☐ Yes: _____

Does your child use corrective or adaptive equipment, such as glasses, leg braces, crutches, walker, or wheelchair? ☐ No ☐ Yes: _____

Medications

Please list all current medicines, supplements, and homeopathic remedies your child is currently taking:

Medicine: *Dose:* *Prescribed to treat:*

_____

_____

_____

Previous medications for ADHD, mental health diagnoses? _____

Development/Behavioral/Mental Health History and Therapies

Has your child had any of the following? ☐ ADD/ADHD ☐ Anxiety ☐ Depression ☐ Speech/language difficulty ☐ Fine/gross motor/coordination difficulty

☐ Other: _____

Please list any therapists, counselors, or agencies who have worked with your child: ☐ None

Service or agency: *Location:* *Dates:*

_____

_____

_____

_____

Did your child have any attachment or bonding difficulties before the age of 5? ☐ No ☐ Yes

If yes, please explain: _____

Does your child participate in any community activities, such as sports, clubs or religious group?

☐ No ☐ Yes: _____

Do you have concerns with how your child plays or interacts with other children? _____Social skills? _____

Does child seek same age friends? ☐ No ☐ Yes Do same age friends seek out your child? ☐ No ☐ Yes

If your child is talking, are they easy to understand: ☐ No ☐ Yes

If you child is not talking, how do they communicate? _____

What are your child's favorite activities? _____

_____

What do you consider to be your child's strengths? _____

_____

What do you consider to be your child's weakness? _____

_____

Do you have concerns about your child's behavior? ☐ No ☐ Yes If yes, please describe: _____

_____

Stressors/Traumas:

List any unusual or traumatic events in child's life which may have impacted development and contribute to current problems. This might include birth or death of loved one, divorce, illness in family, frequent moves, physical/sexual/emotional abuse, bullying etc….

Incident	Child's age	Comments

School/Education

Did child attend preschool or Head start? ☐ No ☐ Yes: _____

Is your child currently enrolled in school? ☐ No ☐ Yes

(name of school and district):_____

Grade: _____ Teacher's name: _____

Does your child have an IEP (Individualized Educational Plan)? ☐ No ☐ Yes

If yes, what services do they receive:

_____

Child's classroom: ☐ General Education ☐ General education with pull out ☐ Self-contained classroom

Has the school voiced any behavioral or academic concerns? ☐ No ☐ Yes: _____

Has your child had any of the following problems in school?	Yes	No	Grades
Speech or language			
Reading /dyslexia			
Writing problem			
Spelling			
Math			
Learning disability			
Suspensions			
Repeating a grade			

Development

Please list your child's developmental progress in the following areas:
(Compare your child's development to other children their age. Please check the appropriate box.)

Areas of Development	Same as others	Slower	Faster	**Comments** Please note any deterioration or loss of skills
Smile at parent				
Play peekaboo				
Point to show something				
Make good eye contact				
Sit alone				
Crawl				
Walk alone				
Social skills (sharing, taking turns)				
Self-control skills (impulse control, delaying gratification				
Make consonant sounds (for example: ba-ba)				
First words				
Responds to name				
Use simple command such as "no"				
Speak 2 to 3 word phrases				
Speak full sentences				
Drink from cup				
Eat with utensils				
Undertstands object names				
Obey verbal commands ("Please come here.")				
Get dressed by self				
running				
drawing and art				
catch and throw a ball				
Building things like Legos				
Ride 2 wheel bike with no training wheels				

Family History

Family medical history is an important part of developing a plan of care for your child. Please indicate if anyone in your family has the following conditions:

Condition/Circumstance	Child	Mother	Father	Sibling	Mother's Family	Father's Family
Intellectual disability						
Learning disorder						
ADHD/ADD						
Seizures or epilepsy						
Alcohol abuse						
Drug abuse						
Physical or emotional abuse						
Sexual abuse						
Depression						
Anxiety disorder or panic attacks						
Schizophrenia						
Visual disability or problems						
Deaf or hard of hearing						
Tics or Tourette's Syndrome						
Chronic illness						
Autism spectrum disorder						
Genetic disorder						
Special education services						
Birth defects						
Arrests or incarcerations						
Other:						

Social History

Caregiver Name: _____ Relationship: _____

Employed:_____ Occupation:_____ Age: _____

Highest grade level completed or higher education: _____

Caregiver Name: _____Relationship: _____

Employed: _____Occupation:_____ Age: _____

Highest grade level completed or higher education: _____

Sibling Name: Gender: Age: Lives with child:

_____

_____

_____

Do any other individuals live with the child? ☐ No ☐ Yes

Please list: _____

Discipline:

What methods have been used to improve the child's behavior at home and what methods have worked best?

	Yes	No	Comments
Verbal reprimands			
Spanking			
Withdrawal of privileges			
Grounding			
Rewards			
Time Out			

Have you participated in any parenting trainings or classes? ☐ No ☐ Yes (please indicate which one)

☐ Parent Child Interaction Training (PCIT) ☐ Triple P (Positive Parenting Program) Incredible Years Other

Do you have any religious or cultural beliefs that are important for us to know when providing care?

☐ No ☐ Yes: _____

_____

Is there anything else that you would like us to know about your child? _____

_____

_____

_____

My child currently has the following services in place:

- ☐ Developmental Disabilities Administration (DDA), DDA Case Worker: _____
- ☐ Social Security/SSI
- ☐ Birth – 3 Services (ESIT through Opportunity Counsel or Whatcom Center for Early Learning) Family Resource Coordinator: _____
- ☐ Occupational Therapy, Physical Therapy, Speech Therapy (where):_____
- ☐ Applied Behavioral Analysis (ABA): _____

I would like more information about:

- ☐ Developmental Disabilities Administration (DDA)
- ☐ Social Security/SSI
- ☐ Counseling Resources (for child, sibling, family members)
- ☐ Transition to Adult Care (guardianship, vocational training, independent living)
- ☐ Parent Support (Parent to Parent, The Arc, etc.)
- ☐ None of the above

Appendix H. COE Evaluation Requirements

The primary responsibility of an Autism COE prescribing ABA under a Medicaid benefit is to **accurately diagnose autism spectrum disorders** and to **determine the medical necessity for applied behavior analysis therapies (ABA)** including multi-disciplinary treatment recommendations (WAC 182-531A-0500 and -0800).

COE evaluations should include, but not be limited to, the following information:

Patient/Provider Identifiers

- ☐ COE information including provider name, degree/credentials, organization name, NPI, contact information, and point person for paperwork issues
- ☐ Patient information including patient ProviderOne number, patient DOB, Parent/guardian name(s), and contact information

Record Review

- ☐ Medical records *(e.g., chart review, labs, diagnostics)*
- ☐ Educational records *(e.g., IFSP/IEP/504 plan)* and teacher report
- ☐ Therapy records *(e.g., speech, occupational therapy)* and therapist report
- ☐ Previous psychological or developmental evaluations

General Interview and Observation

- ☐ History of Presenting Concerns and Current Functioning
- ☐ Medical and Health History *(e.g., pregnancy/birth, medications, immunizations, allergies, hospitalizations, genetic testing, medical diagnostics)*
- ☐ Vision and audiology screening results
- ☐ Review of Systems
- ☐ Developmental history (e.g., developmental milestones)
- ☐ Family and Social History
- ☐ Education and Therapy History
- ☐ Physical exam/behavioral observations

ASD-Focused Interview and Observation

- ☐ Structured diagnostic interview focusing on DSM-5 ASD presentation
- ☐ Reported and observed differences in social communication
- ☐ Reported and observed differences in behavior
- ☐ Autism screening and/or diagnostic tool results *(e.g., M-CHAT-R/F, ASQ, STAT, CARS-2, ADOS, MIGDAS-2; see Appendix I for list of tools)*

Documentation and Referrals

- ☐ Review of pertinent cognitive, speech/language, motor, behavioral, or adaptive testing to rule out other explanations for presenting concerns
- ☐ Diagnosis and summary, including a DSM-5 checklist *(see Appendix J)*
- ☐ Individualized multidisciplinary treatment recommendations and related referrals *(e.g., occupational or speech therapy)*
- ☐ Statement of medical necessity for ABA if appropriate *(see Appendix L for referral requirements/template)*

Hint: Using a template can help you include all required information. See Appendix J. Documentation and report templates, including a DSM-5 checklist. You can see other templates and protocols on the COE Quick Start and Supporting Materials Google Drive folder.

Appendix I. Screening and diagnostic tools

List of common tools arranged by type, age range, and other features (last edited 4/15/2025)

Note: The tools in this chart are not exhaustive or direct recommendations, but options to consider when designing your evaluation workflow. You may find that bolded tools (listed first) have greater accessibility/ease of use in primary care settings.

	Young Children (~1-4yrs)	Children/Adolescents (~4-18yrs)	Adults (~18yrs+)
Record Requests	ESIT *(Early Support for Infants and Toddlers)* Outside evaluation and therapy records Teacher/provider questionnaires	IEP *(Individualized Education Program)*/504 plan Outside evaluation and therapy records Teacher/provider questionnaires	Work/employment history Outside evaluation and therapy records Teacher/provider questionnaires
Questionnaire screening tools	**M-CHAT-R/F *(Modified Checklist for Autism in Toddlers, Revised with Follow-up)*** CASD *(Checklist for Autism Spectrum Disorder)* CSBS-ITC *(Communication and Symbolic Behavior Scales, Infant Toddler Checklist)* Q-CHAT *(Quantitative Checklist for Autism in Toddlers)*	**SCQ *(Social Communication Questionnaire)*** ASRS *(Autism Spectrum Rating Scales)* CASD *(Checklist for Autism Spectrum Disorder)* SRS-2 *(Social Responsiveness Scale, Second Edition)*	**SCQ *(Social Communication Questionnaire)*** †AQ-10 *(Autism Quotient)* †CAT-Q *(Camouflaging Autistic Traits Questionnaire)* †RAADS-R *(Ritvo Autism Asperger Diagnostic Scale–Revised)*
Observational screening tools	**(TELE) ASD-PEDS** RITA-T *(Rapid Interactive Screening Test for Autism in Toddlers)* STAT *(Screening Tool for Autism in Toddlers & Young Children)*	**CARS-2 *(Childhood Autism Rating Scales, Second Edition)*** CASD *(Checklist for Autism Spectrum Disorder)* AMSE *(Autism Mental Status Exam)*	
Parent/caregiver interview tools	**TASI *(Toddler Autism Symptom Interview)*** PIA–CV *(Parent Interview for Autism, Clinical Version)* OHSU DSM-5 Parent Interview *(Preschool)*	**OHSU DSM-5 Parent Interview *(School-age)*** ADI-R *(Autism Diagnostic Interview, Revised)* MIGDAS-2 *(Monteiro Interview Guidelines for Diagnosing the Autism Spectrum, Second Edition)*	
Observational diagnostic tools	**CARS-2 *(Childhood Autism Rating Scales, Second Edition)*** ADOS-2 *(Autism Diagnostic Observation Schedule, Second Edition)* MIGDAS-2 *(Monteiro Interview Guidelines for Diagnosing the Autism Spectrum, Second Edition)*		
Adaptive functioning tools	**ABAS-3 *(Adaptive Behavior Assessment System, Third Edition)*** Vineland-3 *(Vineland Adaptive Behavior Scales, Third Edition – Interview or caregiver self-report)*		

†These tools have limited evidence base for use as screening or diagnostic tool; however, given the lack of tools for adult populations that are included as they may help you gather additional qualitative information to use during your assessment.

List of tools with details training, and costs arranged by type and alphabetically (last edited 4/15/2025).

Note: Time and costs vary based on which version of the tool you choose to get (e.g., paper or online, hand score or scoring software). Costs in the table below may not reflect your actual start-up costs, but are intended to give an estimate of costs.

Tool	Age-range	Time to administer	Training	Start-up cost	Cost of ongoing use	Languages offered	Publisher link
Observational and interview tools							
ADI-R	All ages	1.5-2.5 hour interview	Self-study ($1,142 video)	$415 kit (manual & 10 protocols)	$152/pack of 5 +$32/ per 10 algorithm forms	Many (15+)	https://www.wpspublish.com/adi-r-autism-diagnostic-interviewrevised.html
ADOS-2	All ages (5 versions)	40-60 minute direct testing	Workshop ($600) and/ or Self-study ($1,329 video)	$2695 kit (manual, test materials, & 50 protocols)	$90/pack of 10 for each module	Spanish	https://www.wpspublish.com/ados-2-autism-diagnostic-observation-schedule-second-edition
AMSE	All ages	5-10 minute scoring (based on your clinical observation)	Self-study (free video)	N/A; no standardized test materials	N/A	N/A	https://autismmentalstatusexam.com/
CARS-2	All ages (2 versions)	5-10 minutes scoring (using your interview record review, observation)	Self-study ($150 manual)	$308 kit (manual & 75 protocols; no standardized test materials)	$76/pack of 25 for each version	Italian, Bulgarian	https://www.wpspublish.com/cars-2-childhood-autism-rating-scale-second-edition.html
MIGDAS-2	All ages (2 versions)	60-90 minute observation; 60-90 minute interview	Self-study ($151 manual)	$314 kit (manual & 25 protocols; no standardized test materials)	$46/pack of 5 for each version	N/A	https://www.wpspublish.com/migdas-2-monteiro-interview-guidelines-for-diagnosing-the-autism-spectrum-second-edition.html
RITA-T	Under 3	5-10 minutes	Self-study ($175 video)	$65 kit (test materials & protocols)	N/A	Spanish, Portuguese	https://www.childrenshospital.org/research/labs/rita-t-research

STAT	Under 3	20 minutes	Self-study (included w/ kit)	$500 kit (test materials, manual, & protocols)	$25/pack of 25 protocols	N/A	https://stat.vueinnovations.com/licensing
TASI	Under 3	30-40 minute interview	Self-study (free)	N/A	N/A	Arabic, Czech, Spanish, Portuguese	https://www.mchatscreen.com/tasi/
(TELE) ASD-PEDS	Under 3	15-30 minutes	Self-study (free)	N/A (register to access)	N/A	N/A	https://vkc.vumc.org/vkc/triad/provider-portal/
PIA-CV	Under 6	30-40 minute interview (also has a parent report form)	Self-study (free)	N/A	N/A	Spanish	https://uwreadilab.com/tools-materials/
Questionnaires							
ABAS-3	All ages (5 versions)	10-20 minutes	Self-study	$436-$616 (manual & 25 protocols, varies based on version)	$122/pack of 25 for each version	Spanish	https://www.wpspublish.com/abas-3-adaptive-behavior-assessment-system-third-edition
ASRS	Ages 2-18 (2 versions)	5-20 minutes	Self-study	$125 manual; $105/pack of 25 forms	$105/pack of 25 for each version	Spanish	https://www.pearsonassessments.com/store/usassessments/en/Store/Professional-Assessments/Behavior/Autism-Spectrum-Rating-Scales/p/100000354.html
AQ-10*	Ages 5+	5 minutes	Self-study	Free	N/A	Many (5+)	https://www.autismresearchcentre.com/tests/
CASD	Up to 16	15 minutes	Self-study	$150 kit (manual & 25 forms)	$68/pack of 25 forms	N/A	https://www.wpspublish.com/casd-checklist-for-autism-spectrum-disorder
CAT-Q*	Ages 16+	10-30 minutes	Self-study	Free	N/A	N/A	https://link.springer.com/article/10.1007/s10803-018-3792-6 (see supplement)
CSBS-ITC	Under 6 (w/ language delay)	5-25 minutes	Self-study	$66.95 manual, forms are free	N/A	N/A	https://brookespublishing.com/product/csbs-dp-itc/

M-CHAT-R/F	Under 30 months	5-30 minutes	Self-study	Free	N/A	Many	https://www.mchatscreen.com/
Q-CHAT	Under 30 months	5-30 minutes	Self-study	Free	N/A	Many	https://www.autismresearchcentre.com/tests/quantitative-checklist-for-autism-in-toddlers-q-chat
RAADS:R*	Ages 18+	10-30 minutes	Self-study	Free	N/A	N/A	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3134766/ (See Appendix A)
SCQ	Ages 4+ (2 versions)	5-10 minutes	Self-study	$228 kit (manual & 40 forms	$20/pack of 20 forms	Many	https://www.wpspublish.com/scq-social-communication-questionnaire.html
SRS-2	Ages 2+	15-20 minutes	Self-study	$291 child or adult kit (manual & 25 of each version)	$88/pack of 25 for each version	Spanish	https://www.wpspublish.com/srs-2-social-responsiveness-scale-second-edition
VABS-3	All ages (2 versions)	30-60 minutes (also has an interview form)	Self-study ($185 manual	$195 manual and $113/pack of 25 for each version	$113/pack of 25 for each version	Spanish	https://www.pearsonassessments.com/store/usassessments/en/Store/Professional-Assessments/Behavior/Adaptive/Vineland-Adaptive-Behavior-Scales-%7C-Third-Edition/p/100001622.html

*Use with caution. These tools have limited evidence base for use as a screening or diagnostic tool; however, they may help you gather additional qualitative information to use during an evaluation.

Appendix J. Documentation and report templates

Note: word document version at https://medicalhome.org/docs/COE_quick_start_AppendicesOnly.docx . Additional template examples can be found under the COE Quick Start and Supporting Materials Google Drive folder.

Non-EMR template example
ASD EVALUATION VISIT

Presenting Concern:

PAST MEDICAL HISTORY:
Perinatal complications or exposures:
Birth/Infancy:
Hospitalizations:
Specialty Care:

Vision:
Hearing:

Family History:
Social History:

EDUCATION:

THERAPIES/SERVICES:

FORMAL TESTING/EDUCATIONAL ASSESSMENTS/QUESTIONNAIRES: *(e.g., ASQ, MCHAT, ADOS)*

DEVELOPMENT (hx and current):
Gross Motor:
Fine Motor:
Adaptive: *(clothes off/on, feeds self, toilet trained)*
Social Skills: *(played peekaboo, responds to name)*

SOCIAL COMMUNICATION DOMAIN:

1. **Social/Emotional Reciprocity:** difficulty initiating, responding to and sustaining engagement with others; participation in social interactions primarily on own terms; delays in development of shared joint attention; decreased response to name being called; decreased social smiling; communication primarily for needs-based purposes; decreased showing of objects (e.g., decreased showing items to parents without need for help), decreased sharing interest, activities or emotions with others; diminished imitation skills; decreased seeking/offering comfort to others; decreased response to physical affection, and difficulty participating in simple back and forth conversations (e.g. LIST CONVERSATIONAL CHARACTERISTICS).
2. **Non-verbal communicative behaviors used for social interaction:** avoidant OR inconsistent use of eye contact during social interaction, poor coordination of eye gaze with other means of communication (e.g. facial expressions, verbalizations), decreased use of gestures and body language (e.g. diminished pointing and other gestures), use of others' bodies as a tool for communication, and decreased use of facial expressions to communicate feelings.
3. **Developing maintaining and understanding relationships:** including diminished interest in/initiations with peers, reduced interactive play, preference for solitary play, difficulty with turn taking

RESTRICTED AND REPETITIVE DOMAIN:

1. **Stereotypic or repetitive motor movements, use of objects, or speech:** including motor mannerisms (e.g., body tensing when excited, hand flapping, spinning, walking on toes, jumping, rocking), repetitive actions on objects (e.g., lining up, sorting, and/or spinning objects and repeating preferred actions with objects), interest in the mechanics of objects, non-functional/repetitive play (e.g., playing with toys not as they are intended), and repetitive use of language (e.g., presence of echolalia, scripted language, jargon, odd/high pitched vocalizations, use of made-up words).
2. **Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behaviors:** including difficulty with transitions and change, rigidity (e.g., eating rigidities, items must be in a specific place), insistence on routines/rituals (e.g., certain bath time order, sleep time), becomes upset when routines are disrupted (e.g., upset when parent take an alternate route in car, distressed by change in daycare routine), distress if minor changes occur in environment (e.g., moving furniture, a parent with new hairstyle/glasses), insistence on others' participation in routines.
3. **Highly restricted, fixated interests that are abnormal in intensity or focus:** including presence of restricted interests, preoccupation with unusual objects (e.g., string, tearing paper, water, toilets, vacuums), excessively circumscribed interest (e.g., needing to have something in both hands, carries spoons/unusual object all day)
4. **Hyper- or hypo-reactivity to sensory input or unusual interests in sensory aspects of the environment:** including tactile (e.g., EXAMPLE), auditory (e.g., EXAMPLE), visual (e.g., EXAMPLE), taste (e.g., EXAMPLE), or smell (e.g., EXAMPLE) sensitivities, as well as sensory seeking behavior (e.g., EXAMPLE).

OTHER BEHAVIORS: self-regulation, attention & executive function, oppositional and aggressive behavior, anxiety, depression.

REVIEW OF SYSTEMS:
Growth:
Diet/GI:
Elimination:
Neuro:
Sleep:

Physical Examination/Observations:
(this might refer to previous visit)

ASSESSMENT/DX:
Difficult Behavior
Speech Delay

PLAN:
Refer to Early Intervention for SCAP Eval if not already done
? Refer for ADOS
Return for feedback session after SCAP eval and/or ADOS completed/information reviewed (if it's after ADOS then it's Results Visit, if it's after COE eval then it's Eval Visit 2)
-Given info on ABA and encouraged to call and find out where can be seen and get on waitlist.
-f/u 4-6 weeks after SCAP eval or ADOS done.
ASD EVAL VISIT 2

HPI:
Seen previously in our office on (dates)
Evaluations completed since last visit (SCAP eval)
Enter any new information into the categories or reference the attached note.

SOCIAL COMMUNICATION DOMAIN:

Social/Emotional Reciprocity:

Non-verbal communicative behaviors used for social interaction:

Developing maintaining and understanding relationships:

RESTRICTED AND REPETITIVE DOMAIN:

Stereotypic or repetitive motor movements, use of objects, or speech:

Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behaviors:

Highly restricted, fixated interests that are abnormal in intensity or focus:

Hyper- or hypo-reactivity to sensory input or unusual interests in sensory aspects of the environment:

OTHER BEHAVIORS:

PLAN:
-NOT ASD-->make sure set up with appropriate therapies
-Suspect ASD-->refer for ADOS, plan to f/u 4-6 weeks

ASD RESULTS VISIT

HPI:
Seen previously in our office on (dates)
Evaluations completed since last visit (ADOS, SCAP eval)
Enter any new information into the categories

ASSESSMENT:
Based on prior evaluations and assessments is found to have
(speech delay as well as deficits in social communication and social interaction across multiple contexts. S/He has abnormal social approach, no conversational skills, minimal social/emotional reciprocity, limited initiation of and response to social interaction, poorly integrated verbal and nonverbal communication, reduced eye contact, and difficulties in sharing imaginative play. He also has restricted, repetitive patterns of behavior such as lining objects, spinning in circles, and difficulty with transitions. He does not share interests with others and does not respond to his name being called. Based on history and examination, the patient meets the DSM V criteria for autism spectrum disorder. It is not clear whether this is with intellectual disability due to the young age and limited specific testing but he does have language impairment.)

Giving results to family, make sure to bring out positives: attention to detail, deep focus/concentration, observational skills, absorb and retain facts, visual skills, expertise, methodical approach/analytical/spotting patterns, novel approaches/unique thought processes, creativity, tenacity&resilience, accepting of difference, integrity/honesty/commitment.

PLAN:
If NOT ASD-->make sure set up with appropriate therapies, refer back for f/u development with pcp in 6 months.
If UNCERTAIN ASD-->refer to SCH, refer back to pcp for f/u development in 6months.

If YES ASD-->
1. Would greatly benefit from early intervention or an individualized educational program through the school district. Early services can be provided in-home and through the developmental preschools and later services can be provided through public and private schools.

2. Would greatly benefit from intensive Applied Behavioral Therapy. Letter supplied to family today that serves as an order for ABA.

4. Parent Education and supports: handout provided on Autism resources, DDA, and SSI

3. Return to clinic in 1-2months (at that visit 1-2months later: discuss genetics, find out where things are at with therapies and ABA, refer back to see pcp in 1-2 months)

Thank you to Emily Bianconi, ARNP, Skagit Pediatrics, Mount Vernon, WA for sharing this template.

Note: word document version at https://medicalhome.org/docs/COE_quick_start_AppendicesOnly.docx . Additional template examples can be found under the COE Quick Start and Supporting Materials Google Drive folder.

EMR-compatible template example

ASD EVALUATION VISIT

Patient Name: @NAME@
DOB: @DOB@

Autism Evaluation
Date of Service: @ED@

Primary Care Provider is @PCP@.

Full intake materials provided were reviewed including a detailed health questionnaire and behavioral questionnaire using the Social Communication Observation Tool and the Checklist for Autism Spectrum Disorder - Short Form (CASD-SF) which is a combination of questions from multiple autistic spectrum questionnaires focused on the DSM 5 criteria for autism.

Chief Concern: @FPREFNAME@ is a @AGEPEDS@ @SEX@ who presents for a diagnostic assessment specific to autism spectrum disorder in the context of speech delay and behavioral concerns.

Primary concern(s): ***
Parent first became concerned when @FPREFNAME@ was ***.

@FPREFNAME@ is in *** grade at *** (*** SD). He/she does/does not receive services.

Pregnancy: Mom was *** yo and dad was *** yo at time of delivery. Good pregnancy. No history of miscarriage. No etoh/tobacco/drugs.

Birth: Born at *** weeks via ***. BW ***. Passed newborn hearing screen. No problems after delivery. This is their *** child.

Medical history: Healthy infant. *** No hospitalizations or surgeries.

Developmental history: First sat at *** months, crawled at *** months, walked at *** months. First word at *** months and 2 word phrases at *** months. First point at *** months and first smile at *** months.
Head circumference was ***normal.

Medications: @CURRENTMEDS@
Allergies: No Known Allergies

Immunizations: Up to date.

Vision: No concerns.

Hearing: Hearing tested at birth and normal.

Sleep: ***

Diet: ***

Elimination: No constipation. Toilet trained at *** yo.

Family History: No family history of autism.

Social History: Lives at home with mom, dad and ***.

Stressors/Traumas: ***.

Favorite activities: ***.

Strengths: ***. Loving supportive family.

Challenges: ***

Current Development:

Social Communication Observation Tool

Communication:
Delay in, or total lack of, the development of spoken language:
Difficulty holding conversation:
Unusual or repetitive language:
Play that is not developmentally appropriate:

Restricted, Repetitive Stereotyped Behaviors/Movements:
Interests that are narrow in focus, intense, or unusual:
Unreasonable insistence on sameness/routines:
Repetitive motor mannerisms:
Preoccupation with parts of objects:

Social Skills:
Lack of social or emotional reciprocity:
Difficulty using nonverbal behaviors to regulate social interaction:
Little sharing of pleasure, achievements, or interests with others:
Failure to develop age-appropriate peer relationships:

Associated Concerns:
Unusual sensory interests:
Unusual responses to sensory input:

Motor skills:
Gross motor:
Fine motor:

Adaptive*:*

Checklist for Autism Spectrum Disorder - Short Form (CASD-SF):
Score

FORMAL TESTING/EDUCATIONAL ASSESSMENTS/QUESTIONNAIRES:
Teacher Interview Form completed by *.**
Child's school program: ***
Child's academic functioning: ***
Child's communication skills: ***
Child social functioning in structured settings: ***
Child social functioning in unstructured settings: ***
Quality of student's peer relationships: ***
Restricted or repetitive behaviors: ***
Concerns for autism spectrum disorder: ***
Social problems ***
Academic problems ***
Behavior problems ***
Description of behavior problems at school: ***

Review of systems:
Constitutional: No growth concerns. HEENT: Normal hearing testing at birth. No vision concerns. Cardiac: No heart problems. Respiratory: No breathing problems. GU: No GU problems. GI: No nausea, vomiting, diarrhea or constipation. Selective eater. Skin: No unusual birthmarks and no rashes. Neurological: No history of seizures or head injury. Sleep: There are sleep difficulties.

Physical Examination:
There were no vitals taken for this visit.
General: Alert and well-nourished; No acute distress
Skin: no rashes
Eyes: Non-injected.
Head: Normocephalic
Ears: Normal position/morphology
Nose: No lesions; No discharge
Mouth: mucous membranes moist
Lungs: Respiratory effort normal
C/V: Not performed
Abdomen: Not performed
Neuro: Grossly normal; interaction appropriate for age

Exam done with help of parent.

Assessment/Plan:
@FNAME@ is a @AGEPEDS@ @SEX@ with speech delay and characteristics concerning for autism.

Plan for in person autism assessment tool. Appointment scheduled.
Referral to audiology.

The pros and cons of a video visit for providing this care was reviewed with the patient's parent(s), and their verbal consent has been given to deliver this visit.

This visit was conducted real time, via synchronous interactive video & audio conferencing technology, utilizing the HIPAA compliant MyChart platform. Patient and their family are located at home and PROVIDER NAME is located remotely in his/her home office, both within the state of Washington.

Time spent : E/M code was selected based on *** minutes spent on the date of encounter reviewing pertinent history and previous diagnostics, performing medically appropriate examination and evaluation, ordering diagnostic tests and/or medications, counseling and education to patient/family/caregiver. This excludes activities performed by clinical staff.

ASD RESULTS VISIT
Patient Name: @NAME@
DOB: @DOB@

AUTISM EVALUATION
Date of Service: @ED@

@FNAME@ is seen today for the second part of ***his/her autism evaluation using the ***. He/she is accompanied by *** parent.

UPDATES:

@VITALS@

PROCEDURE: *

EVALUATION RESULTS: *

ASSESSMENT/PLAN:
@FNAME@ is a @AGEPEDS@ @SEX@ with speech delay. *** exhibited challenges regarding effective social communication (both verbal and nonverbal), social interaction, as well as atypical restricted and repetitive behaviors (i.e. strong/repetitive interests, characteristic body use). Based on review of records, history, examination and observations, the patient meets the DSM V criteria for autism spectrum disorder. It is not clear whether this is with intellectual disability due to his/her*** young age and limited specific testing but there is language impairment.

*** demonstrates a number of strengths that include: . *** has supportive family members who are strong advocates for ***. With appropriate intervention to address difficulties in language, social skills, social communication, and behavior, the prognosis seems favorable for *** to make positive gains in these areas.

1. Autism Spectrum Disorder with accompanying language impairment, requiring substantial support (level ***)

2. Speech and language delay

3. ***

Recommendations were developed based on records review, assessments, observations and caregiver interview completed by PROVIDER NAME as a certified autism specialist through the Washington State Center of Excellence. PROVIDER NAME recommends that the report and recommendations be shared with all professionals providing services for your child.

RECOMMENDATIONS
1. Continue regular visits with your doctor. Continue with @FNAME@'s *** therapy.

2. If your child is older than 3, it is recommended that @FNAME@'s IEP be revised to incorporate an autism diagnosis. *** will benefit from specially designed instruction in the areas of social-emotional, adaptive, cognitive, and communication skills as well as sensory accommodations. Contact ARC for an IEP parent mentor if you wish for extra

parental support. If your child is younger than 3, make sure you send this report to your local early intervention program your child is enrolled in so they can have this information and modify their services appropriately.

3. @FNAME@ would benefit from evidence-based intensive behavioral intervention using the methods such as applied behavior analysis (ABA) as part of *** educational curriculum at home or school. Intervention centers and private therapists can be located through https://featautismguide.wordpress.com/ and by contacting the ARC in your local community. Call and get on as many lists as you can and regularly call them back every few weeks to check on your child's status. Be patient, it takes many months to get accepted due to long waiting lists. ABA agencies may request a copy of your child's report and DSM 5 checklist. Item # 4 below is a formal order for ABA therapy which you can highlight and share with the agencies when you apply.

4. Many private insurance companies cover these services; therefore, through this report, **I am prescribing ABA services for @NAME@. The behaviors and skill deficits are having an adverse impact on *** development as documented in this report. *** is exhibiting functional impairments across domains that interfere with the ability to participate adequately in home and community settings and will likely impact functioning in school. Applied behavior analysis (ABA) services are ordered given the adverse impact of @FNAME@'s behaviors and core impairments.**

ABA therapy has changed over the years since it was first developed. Some in the autism community hold strong views against its application given, in part, to the more negative reinforcement techniques that were previously employed. ABA is an individually designed program that is prescribed to specifically meet the needs of your child and his or her behaviors and social/sensory needs. The more your child has targeted behaviors or social or sensory deficits you really wish to work on and modify, the more likely your child would benefit from ABA therapy. It may not be the best fit for every child. ABA is now primarily based on positive reinforcements and has evolved a lot since its inception and when properly employed by skilled therapists it can have very positive benefits. It is recommended you apply and get on waiting lists and then read more and consider if you feel it would be in the best interest of your child.

5. @FNAME@ may benefit from additional intervention with private community-based speech and occupational therapists in order to support *** communication and sensory needs.

6. @FNAME@'s family may benefit from continued parent support and education. The ARC of MODIFY FOR YOUR COUNTY (email; phone) offers support groups and lectures for parents of children with special needs.

7. @FNAME@'s family may be interested in accessing the 100 day kit from Autism Speaks, which is a resource for newly diagnosed families that can be accessed on the Autism Speaks website: http://www.autismspeaks.org/family-services/tool-kits/100-day-kit

8. @FNAME@ may qualify for state support and other funding sources. Developmental Disabilities Administration is part of the Department of Social and Health Services (DSHS). Any person who has a qualifying developmental disability that starts before the age of 18 and is expected to continue indefinitely may be eligible for DDA services. Eligibility is not based on a family's income. The following site includes the application and instructions to fill it out: https://www.dshs.wa.gov/dda/consumers-and-families/eligibility. Supplemental Security Income (SSI) is a federal income supplement program designed to help people with disabilities and the elderly who have little or no income. It is available when a family meets income eligibility guidelines and the child meets SSI disability criteria. For more information go towww.ssa.gov/applyfordisability/child.htm or call 1-800-772-1213.

9. Your doctor will order special lab tests to look for genetic causes or reasons for @FNAME@'s delays. You are busy now so it is ok to wait on these tests for a few months. There is also a research study that is being conducted at Children to look for genetic causes of autism, if you are interested.
https://sparkforautism.org/why/
Your doctor can also write a prescription for diapers or pull-ups (if needed).
You can also get a prescription for a disability parking placard.

10. Contact Ben's Fund (www.bensfund.org) to apply for up to $1000 in free grant money to help with any necessary items, like things to keep *** safe. It is pretty easy to get this money so definitely apply! It is specifically for kids with ASD.

11. @FNAME@ is also eligible to participate in Camp Prov, a supported summer camp experience for children with special needs (3+ years old) and siblings too! (https://washington.providence.org/locations-directory/r/regional-medical-center/donate-and-volunteer/volunteer/summer-opportunities/camp-prov). Other summer programs for children with special needs can be located through local parks and recreation centers or at www.cshcn.org.

12. There are informative videos you can watch through the Autism Clinic at Seattle Childrens Hospital. https://www.seattlechildrens.org/health-safety/keeping-kids-healthy/development/autism-101/ https://www.seattlechildrens.org/health-safety/keeping-kids-healthy/development/conversations-about-autism/

13. I will follow up with you in a few months to see how @FNAME@ is doing.

It was a pleasure to work with you and @FNAME@. *** is fortunate to come from a very loving and supportive home. Please feel free to call me or send me a message with any questions regarding this report.

Peds time spent: Total of *** minutes spent today with patient/patient family and in counseling and/or activities in coordination of care related to play observation- chart review, report writing and communication, labs and referrals as described and recorded today in the visit.

Thank you to Susana Myers, DO, for compiling and sharing this template

Clinical Diagnosis: DSM-5 Checklist

Note: word document version at https://medicalhome.org/docs/COE_quick_start_AppendicesOnly.docx or under the COE Quick Start and Supporting Materials Google Drive folder.

DSM-5 Criteria	**Autism Spectrum Disorder**
NOTE:If the individual has a well established DSM-IV diagnosis of autistic disorder, Asperger's disorder, or PDD-NOS, please check this box. Please then either reclassify them using the below criteria or complete and attach the DSM-IV checklist to verify diagnosis.	
A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following, currently or by history:	
1. Deficits in social-emotional reciprocity, ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions.	
2. Deficits in nonverbal communicative behaviors used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communication.	
3. Deficits in developing, maintaining, and understanding relationships, ranging, for example, from difficulties adjusting behaviors to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers.	
Social-Communication Domain Total (must meet all 3):	
Specify Current Severity: (circle on in column on right)	**Requires**: Support (1) Substantial Support (2) Very Substantial Support (3)
B. Restricted, repetitive patterns of behavior, interests, or activities as manifested by at least two of the following, currently or by history:	
1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypeis, lining up toys or flipping objects, echolalia, idiosyncratic phrases).	
2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat same food every day).	
3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interests).	
4. Hyper-or hyporeactivity to sensory input or unusual interest in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement).	
Restricted and Repetitive Domain Total (must meet at least 2):	
Specify Currently Severity: (circle on in column on right)	**Requires**: Support (1) Substantial Support (2) Very Substantial Support (3)

C. Symptoms must be present in the early developmental period (but may not become fully manifest until social demands exceed limited capacities, or may be masked by learned strategies later in life).	
D. Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning.	
E. These disturbances are not better explained by intellectual disability or global developmental delay.	
Autism Spectrum Disorder Criteria Met?	**YES/NO**
With or Without Intellectual Impairment?	**WITH/WITHOUT**
With or Without Language Impairment?	**WITH/WITHOUT**
Associated With Any Known: (1] medical/genetic/environmental condition/factor: 2] neurodevelopmental /mental/behavioral disorder, 3] catatonia)	
Provider name: _____ Date: _____ Signature: _____	

Appendix K. Suggested Billing and Diagnosis Codes for COEs & SMART Teams

Current Procedural Terminology (CPT) Billing Table

Category	CPT Code	Estimated Medicaid Reimbursement as of May 2025* (can vary by setting)	Descriptions	Provider Types
Evaluations	99205	$81.65 to $101.10 $120.23 to $150.28 for ages 0-20 years only	Office Visit, New Patient	MD, ARNP, ND
	99215	$65.02 to $83.13 $95.86 to $123.64 for ages 0-20 years only	Office Visit, Established Patient	MD, ARNP, ND
	G2212 (the Medicaid version of 99417)	$17.72 to $18.46	Prolonged services (must be used with 99205 or 99215, up to 3hrs)	MD, ARNP, ND
	90791	$103.28 to $121.40	Psychiatric Diagnostic Evaluation	Psychiatrist, Psychiatric ARNP, Psychologists and other mental health providers
	90792	$96.23 to $110.97	Psychiatric Diagnostic Evaluation with Medical Services	Psychiatrist, Psychiatric ARNP
	96130 96131 [PA for 20 years or older]	$61.55 to $68.63 $42.52 to $49.05	Psychological Testing	Psychologist
	96136	$13.06 to $24.43	Psychological Testing	Psychologist
	96112 96113	$70.31 to $70.87 $32.26 to $34.32	Developmental Testing	MD, ARNP, ND, Psychologist, SLP
	92521 92522 92523 92524	$77.21 $64.53 $132.23 $63.41	Speech and Hearing Evals	SLP
Treatment Planning	99367 [0-20 years]	$46.07 to $63.60		MD, ARNP, ND, Psychologist
Records Review	90885	Considered a bundled service, not payable separately.		MD, ARNP, ND, Psychologist
Add on Codes	90785	$9.18 to $10.32	Interactive complexity	Psychiatrist, Psychiatric ARNP, Psychologist

**The above Medicaid reimbursement rates are from the Health Care Authority fee schedules, specifically the "Physician-related/professional services fee schedules". They can be found here:*
https://www.hca.wa.gov/billers-providers-partners/prior-authorization-claims-and-billing/provider-billing-guides-and-fee-schedules

Evaluation and Management (E/M) Time Based Billing Table (Effective September 2024)

Table 2. Codes for Billing Prolonged Office or Outpatient E/M Visits

Codes	Total Time Required for Reporting*
99205	60-74 minutes
99205 x 1 and G2212 x 1	89-103 minutes
99205 x 1 and G2212 x 2	104-118 minutes

Codes	Total Time Required for Reporting*
99215	40-54 minutes
99215 x 1 and G2212 x 1	69-83 minutes
99215 x 1 and G2212 x 2	84-98 minutes
99215 x 1 and G2212 x 3 or more for each additional 15 minutes	99 or more

* Total time is all of the reportable time, including prolonged time, you spend with the patient on the date of service of the visit.

Source: Centers for Medicare & Medicaid Services. (2024, September). Evaluation and management services guide (MLN006764). Medicare Learning Network®. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/Index.html

Diagnosis Codes

CDC ICD-10 Information: https://www.cdc.gov/nchs/icd/icd-10-cm.htm
World Health Organization ICD-10 Browser tool (look up codes): https://icd.who.int/browse10/2019/en

For first visits at the Seattle Children's Autism Center before a diagnosis has been established, we often bill "**F88: Delayed Social and Emotional Development**" and have had good success in getting reimbursed (*Jen Gerdts, PhD, Clinical Psychologist at Seattle Children's Autism Center*)

- F84.0 Autistic disorder
- Z13.41 Encounter for autism screening

If you have comments or questions, please reach out to Sophie Maleng, ARNP at sophielu@uw.edu.

Last revision May 2025. Table adapted from Suggested Codes for COE Evaluations. Information compiled by Sophie Maleng, MN, PPCNP-BC, ARNP for the Medical Home Partnerships Project (MHPP).

Appendix L. Medicaid ABA order template

Note: word document version at https://medicalhome.org/docs/COE_quick_start_AppendicesOnly.docx. Templates and other supporting documents also found on the COE Quick Start and Supporting Materials Google Drive Folder.

ABA Order template for autism diagnosis

CHILD was formally evaluated on DATE at PRACTICE by PROVIDER, DEGREE. CHILD demonstrated impairments in social interaction, social communication and atypical behavior consistent with Autism Spectrum Disorder (DSM-5 criteria; ICD-10 code F84.0). CHILD's behaviors and skill deficits are having an adverse impact on: 1) development, and 2) social communication. CHILD demonstrates atypical behaviors, as documented on DATE, including functional impairments that interfere with her ability to participate adequately in home, school and community environments.

Since that time, CHILD has continued to have deficits in his functioning. Applied behavioral analysis (ABA) services are ordered at this time, given the adverse impact of CHILD's behaviors and core impairments. There is no equally effective alternative available for 1) reducing severe interfering or disruptive behaviors and 2) increasing pro-social behaviors, and achieving desired behaviors and improvements in functioning. Applied behavioral analysis services are reasonably expected to result in a measurable improvement in CHILD's skills and behaviors.

If further information is required, please do not hesitate to contact PROVIDER at NUMBER.

Sincerely,
PROVIDER
PRACTICE

[Attach the completed DSM-5 checklist and any other supporting documentation from your evaluation, with appropriate ROIs, to reduce the need for back-and-forth communication. Full template can be found on the Autism Resources Google Drive folder.]

ABA order template for non-autism diagnosis

NAME (DOB: _____) is a _____-year-old _____with a history/diagnosis of_____ _____, _____. NAME is a patient at _____ for _____ symptoms as noted in his/her clinic note(s) dated _____.

Applied behavioral analysis (ABA) services are ordered at this time and deemed medically necessary, given the adverse impact of NAME's behaviors and core impairments. There is no equally effective alternative available for reducing severe interfering or disruptive behaviors, and achieving desired behaviors and improvements in functioning. Applied behavioral analysis services are reasonably expected to result in a measureable improvement in NAMES's skills and behaviors. Please see attached reference article to support ABA in neurodevelopmental disorders by Drs. Hagopian and Boelter. If further information is required, please do not hesitate to let me know.

NAME is able to actively participate in ABA therapy.

If further information is required, please do not hesitate to contact CLINICIAN at NUMBER

Sincerely,
Provider Name
Title

[Full template with article and additional references attached can be found on the Autism Resources Google Drive folder.]