## Functional Behavior Assessment

### Assessment Information

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<tr>
<th>Field</th>
<th>Information</th>
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<tr>
<td>Child Name</td>
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<td>DOB</td>
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<td>Gender</td>
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<td>Medicaid #</td>
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<td>Parent/Guardian</td>
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<td>Guardian Relationship</td>
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<td>Primary Phone</td>
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<td>Secondary Phone</td>
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<td>Assessor Name</td>
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<td>Certification type</td>
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<td>Assessor Agency</td>
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**Important!** This report contains privileged and confidential information and may only be released with written parental consent except as provided by law.

February 2014
Reason for Assessment
Describe the reason for the referral including specific behavioral examples

Adaptive Behaviors
Functional strengths and needs in the home, school, community and social settings

Communication Skills
Functional strengths and needs in Receptive, Expressive, Augmented, and Pragmatic Language
ASSESSMENT PROCEDURES AND TOOLS

Indicate types of assessments used:

☐ BASC (Behavior Assessment System for Children, 2nd Edition)
☐ CARS (Childhood Autism Rating Scale)
☐ FAST (Functional Analysis Screening Tool)
☐ MAS (Motivation Assessment Scale)
☐ QABF (Questionnaire about Behavioral Function)
☐ VB-MAPP (The Verbal Behavior Milestones Assessment and Placement Program)
☐ Vineland-II Adaptive Behavior Scale
☐ Other

Describe if “Other”

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

Specify findings from assessments

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
BACKGROUND INFORMATION

Review of Record
*Please describe pertinent findings from prior records reviewed.*

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Medical Information & Health Concerns
*Are there any medical/physical contraindications or health concerns for the use of any specific interventions?*

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Previous Behavioral Interventions and Response to Treatment
*Please indicate what was helpful and what was not.*

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
**CURRENT BEHAVIORAL INTERVENTIONS & RESPONSE TO TREATMENTS:**

Please describe use of ABA treatment, all behavioral/mental health services including medication monitoring, and any ancillary services, such as Occupational Therapy, Physical Therapy, Speech & Language, and social skills groups. Please specify if the services are provided in home, school, or in office setting, as well as the type of communication system, use of evidence based practices and response to treatment for each question. If there are no current interventions, please indicate "N/A".

**SCHOOL**

Please include the interventions from the school positive behavior support plan.

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<th>Response</th>
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**BEHAVIORAL HEALTH SERVICES**

In addition to above, please identify the agency of the behavioral health provider(s) involved.

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**SPECIALIZED MEDICAL SERVICES**

In addition to above, please specify the agency of the specialized medical service provider(s) involved.

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NJ Children's System of Care

Functional Behavior Assessment

Name: ___________________________ Cyber ID# ___________________________ Date of Report: ___________________________

INTERVIEWS
Please list all information sources including parent/legal guardian, school, and others

INTERVIEW #1
Last Name: ___________________________ First Name: ___________________________
Entity, Agency or Relationship to Child: ___________________________
Phone number: ___________________________
Information supplied by source:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

INTERVIEW #2
Last Name: ___________________________ First Name: ___________________________
Entity, Agency or Relationship to Child: ___________________________
Phone number: ___________________________
Information supplied by source:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
OBSERVATIONS

Observer: ____________________________

Observation Date: ____________________

Hours Observed: ______________________

Observation Type: _____________________

Name of Behavior: ____________________

Frequency: ____________________________

Duration: _____________________________

Setting:

☐ Community  ☐ Home  ☐ Social  ☐ Other

Describe specific settings: (Ex: vehicles, stores, restaurants, etc.)

Observation:

*Please include people present for observation, how information was gathered, and details of the observation (including but not limited to special circumstances, unexpected findings and extraneous factors)*

Please summarize data analysis findings:
**BEHAVIORS**

**BEHAVIOR #1**

Name of behavior: 

Describe presentation of behavior in observable terms

<table>
<thead>
<tr>
<th>Function</th>
<th>Identify function(s) of behavior</th>
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<tbody>
<tr>
<td>□ Escape</td>
<td>□ Attention</td>
</tr>
<tr>
<td>□ Sensory</td>
<td>□ Tangible</td>
</tr>
<tr>
<td>□ Other</td>
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Specify if other:

**Setting Events**

Identify the specific setting events or factors which are often associated with an increase in the problem behaviors

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Antecedents
Identify all antecedents to behavior

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Consequences
Identify all consequences of behavior

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Potential Environmental Reinforcers

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
Desired Outcomes/Goals

Behavior 1:

Replacement Behavior Type:

☐ Coping Skill  ☐ General Skill  ☐ Behavior

Functionally Equivalent Skill/Behavior

Identify skills that will be taught to replace inappropriate behaviors.
Identify skills that will be taught to support the expansion of developmental skills identified in this report.
NJ Children's System of Care

Functional Behavior Assessment

Name: ___________________________ Cyber ID# ___________________________ Date of Report: ___________________________

DETERMINATION

Positive Promoting Factors
________________________________________
________________________________________
________________________________________
________________________________________

Potential Barriers
________________________________________
________________________________________
________________________________________
________________________________________

Is intensive in home ABA recommended?  ☐ Yes  ☐ No

Time of Day:
☐ Before School  ☐ After School  ☐ Weekend  ☐ Other

Specify if other:
________________________________________

Setting:
☐ Community  ☐ Home  ☐ Social  ☐ Other

Describe specific settings. (Ex. Vehicles, stores, restaurants, etc)
________________________________________
RECOMMENDATIONS

☐ Intensive in home ABA is not recommended (please explain why).

☐ Intensive in home ABA is recommended. Please list any evidence based practice models and how the services will be coordinated with the existing services in home, school or office settings.