ATAP Provider Survey

Provider Name:

Address:

Phone Number: **Email:**

Name of Person Completing Survey:

I. General Information

A. Years Company established?

B. What is the age range of clients you serve?

C. Number of clients currently serving with ASD?

D. Capacity of clients currently able to serve?

E. Are you willing to travel to rural areas? YES NO

i. If yes, how many miles are you willing to travel from your business address?

F. How many years of experience does your company have providing in-home programs?

G. Do your company's supervisors have experience training and supervising interventionists? YES NO

H. Do your company's supervisors have experience training parents/caregivers? YES NO

I. Do you provide information or educate parents/caregivers on the research to support evidence-based treatment for ASD? YES NO

II. Staffing

A. How many employees do you currently have?

B. Please list the number of employees by category – only one per classification, indicating the employees' highest degree/certification/training. For example: If you staff a Consultant/Supervisor with a BCBA and LBA, they should only be counted once, as an LBA.

Title	# of emp's	Title	# of emp's	Title	# of emp's
LBA		Licensed Psychologist		Interventionist	
LaBA		BcaBA/BCBA Student		Administration/Support Staff	
BCBA		RBT/CABI		Speech Therapist	
BCaBA		Consultant/Supervisor		Occupational Therapist	

C. Do you have bilingual staff? YES NO

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D. What languages?

E. *Please describe ongoing (non-workshop) staff training and how frequently the training occurs:

***500 words max – use additional paper as necessary**

III. Intake

A. Is your intake process typically less than one month? YES NO

B. Do you meet with potential clients during the intake process? YES NO

C. Do you charge for your intake process? YES NO

D. Do you currently have a waiting list? YES NO

E. If so how long can clients expect to wait? YES NO

F. Do you allow potential parents to view treatment or practices on site/in home prior to selection? YES NO

G. *What are the steps of your intake process?

***500 words max – use additional paper as necessary**

IV. Specific Program Services

A. Which curriculum do you use?

B. *Describe how coordination with age-appropriate curriculum will occur:

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***500 words max – use additional paper as necessary**

C. Please give a description of how your data collection process looks:

a. *How is the data summarized?

b. *How often is the data summarized?

***500 words max – use additional paper as necessary**

D. *Please describe what steps will be taken to ensure generalization across environments:

***500 words max – use additional paper as necessary**

E. *Where does therapy and supervision take place?

***500 words max – use additional paper as necessary**

F. *Describe training that will be provided during supervision hours and parent training:

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*500 words max – use additional paper as necessary

G. *Please provide experience in establishing in-home programs:

*500 words max – use additional paper as necessary

H. *Describe methodologies for in-home services:

*500 words max – use additional paper as necessary

I. Referring to the ATAP Provider Manual, what plan types will you serve?

Comprehensive:	YES ☐ NO ☐	Targeted Extensive:	YES ☐ NO ☐
Insurance Assistance:	YES ☐ NO ☐	Therapeutic (Speech/OT/PT):	YES ☐ NO ☐
Targeted Basic:	YES ☐ NO ☐	Social Skills:	YES ☐ NO ☐

V. Billing/Contracts/Collaborations

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A. What are your rates for supervision?

B. What are your rates for interventionist hours?

C. What is your rate for group social skills?

D. What is your rate for individual social skill training?

E. What are your rates for therapeutic services (OT, SLP)?

F. Referring to the ATAP Provider Manual, have you reviewed Aging and Disability's reporting requirements and are you able to meet them knowing Tier price is inclusive? YES NO

G. *What services (not included with regular supervision) are offered at additional cost? (e.g., school observations, session observations, IEP meeting, parent phone calls, miscellaneous reporting)?

***500 words max – use additional paper as necessary**

H. Are you willing to waive those fees for ATAP clients? YES NO

I. *What is your cancellation policy?

***500 words max – use additional paper as necessary**

VI. Insurance Information

A. List insurance companies you are currently contracted with:

B. List insurance companies you are actively billing:

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C. List companies you are currently in-network with:

D. Will you accept Medicaid children? YES NO

VII. Miscellaneous Data

A. *Other Applicable Information:

***500 words max – use additional paper as necessary**

Signature of person completing Survey

Date at completion of ATAP Survey: