Below is a template that providers may use as a WCA. This form can be used in its entirety, or as an example if a provider would prefer to create their own agreement form. If providers choose to use an alternative WCA, it must minimally cover the items addressed within this template.

ADAPTIVE BEHAVIOR SUPPORT (ABS) SERVICES
WRITTEN COLLABORATIVE AGREEMENT (WCA)
BETWEEN

_____

And

_____

This Written Collaborative Agreement (WCA) is entered into between _____ and _____ for the provision of Adaptive Behavior Support (ABS) services under the Illinois Medical Assistance program. _____ and _____are collectively referred to herein as "Parties" or individually as a "Party," "ABS Clinician," or "ABS Technician."

A. PURPOSE

A WCA is required for all ABS Clinicians and ABS Technicians engaged in clinical practice outside of a Behavioral Health Clinic. An ABS Clinician means a Licensed Clinical Social Worker, Licensed Clinical Professional Counselor, Licensed Marriage and Family Therapist, Licensed Clinical Psychologist, Speech Pathologist licensed in Illinois, Occupational Therapist licensed in Illinois, each of whom is specially trained and qualified to provide ABS Services and/or Developmental Intervention Therapy as recognized by the Illinois Medicaid program and consistent with their scope of practice, or a Board Certified Behavior Analyst (BCBA). An ABS Technician means an individual certified as a Registered Behavior Technician (RBT) or an individual age 21 or older with technical training in Developmental Intervention and recognized by the Illinois Medicaid program as qualified to deliver ABS Technician services under the supervision of an ABS Clinician.

B. PARTIES.

ABS TECHNICIAN INFORMATION

1. NAME: _____
2. EMAIL: _____
3. CONTACT NUMBER: _____
4. NPI: _____
5. QUALIFICATIONS *(check all that apply):*
   - ☐ Trained Developmental Technician
   - ☐ Registered Behavior Technician (RBT)
6. RBT CERTIFICATION NUMBER: _____
7. CERTIFICATION EXPIRATION DATE: _____
8. ATTACHMENTS:
   - ☐ Copy of developmental certificate of training
   - ☐ Copy of current RBT Certification
   - ☐ Other *(list)*: _____

ABS CLINICIAN INFORMATION

1. NAME: _____
2. EMAIL: _____
3. CONTACT NUMBER: _____
4. NPI: _____
5. CREDENTIALS (*check all that apply)*:
   - ☐ Board Certified Behavior Analysts (BCBA)
   - ☐ Advanced training in Developmental Intervention (DI)
   - ☐ Licensed Practitioner *(list type)*: N/A
6. LICENSE/CERTIFICATION INFO: (*list for each credential)*
   - Number: Exp. Date:
   - Number: Exp. Date:

7. ATTACHMENTS:

- ☐ Copy of current BCBA Certification
- ☐ Copy of developmental certificate of training
- ☐ Copy of current Licensure
- ☐ Other *(list)*:

RELATIONSHIP OF THE PARTIES

Enter the professional relationship between the Parties (e.g. employee, student intern).

C. ABS SERVICE DELIVERY REQUIREMENTS

1. The Parties shall deliver ABS services to customers of the Illinois Medical Assistance Program in accordance with the policies set forth by the Illinois Department of Healthcare and Family Services (HFS). ABS services are to be delivered by a team trained and/or credentialed in the delivery of Applied Behavior Analysis (ABA) or Developmental Intervention (DI). ABS teams must minimally be comprised of one ABS Clinician and one ABS Technician.

2. The ABS Clinician must provide supervision to the ABS Technician for a minimum of five percent (5%) of all direct ABS services provided. Supervision activities shall include, at a minimum, two face-to-face, real-time contacts per month in the form of the following activities:
   a. Observing, providing behavioral skills training, and delivering performance feedback to the ABS Technician;
   b. Modeling clinical, technical, and professional skills and behavior;
   c. Guiding the development of problem-solving and decision-making with the ABS Technician;
   d. Reviewing clinical documentation (e.g., daily progress notes, data sheets) with the ABS Technician; and,
   e. Overseeing and evaluating the effects of behavior analytic service delivery.

D. SCOPE OF COLLABORATIVE AGREEMENT

1. The parties shall be available to each other for consultation either on site or by electronic access including but not limited to telephone, facsimile and email.

2. A representative sample of patient records shall be reviewed by the ABS Clinician every three months to evaluate that the ABS Technician service delivery is congruent with the ABS Services. Summarized results of this review will be signed by both parties and shall be maintained in the ABS Clinician's practice site for possible regulatory agency review.

3. Disagreement between the ABS Clinician and the ABS Technician regarding a customer's ABS Services that falls within the scope of practice of both Parties will be resolved by a consensus agreement in accordance with current ABS Services or Applied Behavior Analysis literature consultation. In case of disagreements that cannot be resolved in this manner, the ABS Clinician's opinion will prevail.

4. Additional Terms (reserved).

E. CONFIDENTIALITY

Personally identifiable information maintained by both Parties is subject to the confidentiality provisions of Federal and State statutes, rules and regulations, including, but not limited to, Title XIX of the *Social Security Act (42 USC 1396 et seq.)*. When personally identifiable information is exchanged or shared by the Parties, the following rules shall apply: (i) the confidential nature of the information must be preserved; (ii) the information furnished must be used only for the purposes for which it was made available; (iii) assurance must be given that the proper steps shall be taken to safeguard the information; and (iv) access to such information shall be limited to personnel who require the information to perform their duties or for whom access is permitted by statute or regulation. The release of personally identifiable information, data or records by either Party and/or their respective staff to any unauthorized person may subject the releasing Party and their respective staff to criminal and/or civil penalties as imposed by law.

F. TERM

This Agreement shall commence upon full execution by the Parties. This agreement shall be reviewed at least annually and may be amended in writing in a document signed by both Parties and attached to the WCA.

G. TERMINATION

1. Termination on Notice. This Agreement may be terminated by either Party for any or no reason upon _____ days' prior written notice to the other Party.

2. Termination for Cause. In the event either Party breaches this Agreement and fails to cure such breach within _____ days' written notice thereof from the non-breaching Party, the non-breaching Party may terminate this Agreement upon written notice to the breaching Party.

H. MISCELLANEOUS

1. Records Retention. The Parties shall maintain for a minimum of six (6) years from the later of the date of final payment under this Agreement, or the expiration of this Agreement, adequate books, records and supporting documents to comply with the Illinois State Records Act. If an audit, litigation or other action involving the records is begun before the end of the six-year period, the records shall be retained until all issues arising out of the action are resolved.

2. Assignment; Binding Effect. This Agreement, or any portion thereof, shall not be assigned by any of the Parties without the prior written consent of the other Parties. This Agreement shall inure to the benefit of and shall be binding upon the Parties and their respective successors and permitted assigns.

3. Notices. All written notices, requests and communications may be made by electronic mail to the e-mail addresses set forth in Part B above.

4. Headings. Section and other headings contained in this Agreement are for reference purposes only and are not intended to describe, interpret, define or limit the scope, extent or intent of this Agreement or any provision hereof.

I. AGREEMENT

Having read and understood the full contents of this document, the Parties hereto agree to be bound by its terms.

ABS Clinician

Printed Name: _____ License/Cert. #: _____

Signature: _____ Date: _____

ABS Technician

Printed Name: _____ License/Cert. #: _____

Signature: _____ Date: _____