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| --- | --- |
| **ID/DD Waiver Crisis Intervention Log****(Episodic)** | **Name:** |
| **Medicaid Number:** |
| **Date** | **Time Began** | **Time Ended** | **Total Time** |
| **Location(s) where services provided:** |
| **People Involved and Relationship:** |
| **Situation Requiring Support** (Use as much space as needed) |
|  |
| **Action(s) Prior to Crisis Intervention Staff Arrival**(Use as much space as needed) |
|  |
| **Action(s) of Crisis Intervention Staff** (Use as much space as needed) |
|  |
| **Resolution**(Use as much space as needed) |
|  |
| Crisis Plan Implemented [ ]  | Crisis Plan Requires Revision [ ]  | Crisis Plan Needed [ ]  |
|  |  |  |
| **Staff Signature/Credentials** |  | **Date** |
|  |  |  |
| **Clinical Supervisor Signature/Credentials** |  | **Date** |