|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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** | | | |