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| --- | --- | --- |
| **ID/DD Waiver Crisis****Intervention Plan** | **Name:** |  |
| **Medicaid Number:** |  |
| **Provider Agency:** |  |
| Crisis Intervention Team Contact: |  | Phone number: |  |
| Relevant History and Potential Crisis Situation(s): | Current Medications |
| Known Triggers: |
| Action Steps for Home | Action Steps for Community Locations (specify location(s)) | Action Steps for Day Programs |
|  |  |  |
|  |  |  |
| Person/Legal Guardian Signature/Date | Crisis Intervention Team Clinical Supervisor Signature/Credentials/Date | Responsible Crisis Intervention Team Staff Signature/Credentials/Date |
|  |  |  |
| Other Provider Signature/Credentials/Date | Other Responsible Crisis Intervention Team Staff Signature/Credentials/Date | Other Responsible Crisis Intervention Team Staff Signature/Credentials/Date |