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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 | |