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| **ID/DD Waiver Justification for Behavior Support Services** |

| **Name:** |  | **Medicaid Number:** |  |
| --- | --- | --- | --- |
|  |  | **Agency:** |  |
|  |  |  |  |

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| --- | --- | --- | --- | --- | --- | --- |
| Based upon the Functional Behavior Assessment completed | | | |  | | it is recommended |
| that Behavior Support services are warranted. | | | | (date) | |  |
| It is anticipated that approximately |  | hours for |  | | months will be required to implement | |
| the Behavior Support Plan. | |  |  | |  | |

**OR**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Based upon the Functional Behavior Assessment completed, | | |  | it is recommended |
|  | | | (date) |  |
| that direct Behavior Support services are not warranted but there is a need for ***staff training*** | | | | |
| It is anticipated that approximately |  | hours will be required to adequately train staff to manage | | |
| identified behaviors. | | | | |

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| **Behavior Support Consultant Signature/Credentials** |  | **Date** |
|  |  |  |
|  |  |  |
| **BIDD Signature** |  | **Date** |