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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**

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