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| **Medical Verification for ID/DD Waiver**  **Behavior Support and Crisis Intervention Services** |

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| **Person’s Name:** | | | |  | | | | |
| **Healthcare Provider’s Name:** | | | |  | **Office Phone:** | | |  |
| **Healthcare Provider’s Address:** | | | |  | | | | |
| **Proposed Behavior Support/Crisis Intervention Service:** | | | | | | | | |
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| **Healthcare Provider:** Please initial to indicate your agreement or disagreement with each of the items listed below. If you are in disagreement with any of the statements, please summarize on the reverse side of this form your reasons for disagreeing, as well as your recommendations and/or treatment plans. | | | | | | | | |
| **Agree** | | **Disagree** |  | | | | | |
|  | |  | There is no medical reason that this person cannot participate in the proposed Behavior Support/Crisis Intervention Services. | | | | | |
|  | |  | This person presents no symptoms of physical illness that should receive medical treatment prior to starting/continuing Behavior Support/Crisis Intervention services. | | | | | |
|  | |  | This person presents no symptoms of mental illness that should receive medical treatment prior to starting Behavior Support/Crisis Intervention services. | | | | | |
|  | |  | There are no special medical precautions to follow during the implementation of Behavior Support/Crisis Intervention services. | | | | | |
| **Based Upon My Knowledge of This Person:** | | | | | | | | |
|  | He/she can participate in the proposed Behavior Support/Crisis Intervention services. | | | | | | | |
|  | He/she requires medical treatment that must be successfully completed prior to starting Behavior Support/Crisis Intervention services. | | | | | | | |
|  | He/she cannot participate in the proposed Behavior Support/Crisis Intervention services for medical reasons. | | | | | | | |
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| **Signature of Healthcare Provider/Credentials** | | | | | |  | **Date** | |