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| **ID/DD Waiver Request for Additional**  **Behavior Support Services**  **(Use as many pages as necessary and attach most recent Quarterly Review Report)** |

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| **Name:** |  | | | | | **Date:** |  | |
| **Medicaid #:** | | |  | | | **Agency:** | |  |
| **Behavior Consultant:** | | | |  | | **Phone Number:** | |  |
| **# Additional Hours Requested:** | | | |  | | **# Hours utilized to date:** | |  |
| **Target behavior(s):** | |  | | | | | | |
| **Justification for additional services:**  **(why hours are needed and how they will be used)** | |  | | | | | | |
| **Desired goals/outcomes:** | |  | | | | | | |
| **❖BIDD USE ONLY❖** | | | | | | | | |
| **Approved** | | | | | **Disapproved** | | | |