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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** |