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| **ID/DD Waiver Request for Additional**  **Crisis Intervention Services** |

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| --- | --- | --- | --- | --- | --- | --- |
| **Name:** |  | | | **Date:** |  | |
| **Medicaid #:** | |  | | **Agency:** | |  |
| **Behavior Consultant:** | | |  | **Phone Number:** | |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **# Additional hours requested:** |  | **OR** | **# Additional days requested** |  |
| **# Hours utilized to date:** |  | **# Additional Days utilized to date:** |  |

|  |  |  |
| --- | --- | --- |
| **Target behavior(s):** |  | |
| **Justification for additional services:**  **(why hours/days are needed and how they will be used)** |  | |
| **Desired goals/outcomes:** |  | |
| **❖BIDD USE ONLY❖** | | |
| **Approved** | | **Disapproved** |