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| **ID/DD Waiver Request for Additional**  **Crisis Support Services**  **(use as many pages as necessary)** |

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| **Name:** | |  | | **Date:** |  |
| **Medicaid #:** | |  | | **Regional Program:** |  |
| **Program Supervisor:** | |  | | **Phone Number:** |  |
| **Additional # Days Requested:** | |  | | **# Days utilized to date:** |  |
| **Targeted behavior(s):** |  | | | | |
| **Justification for additional services:**  **(why days are needed and how they will be used)** |  | | | | |
| **Desired goals/outcomes:** |  | | | | |
| **❖BIDD ONLY❖** | | | | | |
| **Approved** | | | **Disapproved** | | |