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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** |