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| **ID/DD Waiver Request for Behavior Support**  **and/or Crisis Support** |

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| Name: |  | | | Date: |  | | | |
| Medicaid #: | |  | | Regional Program: | | |  | |
| Support Coordinator: | |  | | SC Phone Number: | | |  | |
| Service(s) Requested: | |  | | Provider Requested: | | |  | |
| Diagnoses: | |  | | | | | | |
| Current Medications: | |  | | | | | | |
| Target Behavior(s): | |  | | | | | | |
| Frequency of behavior(s): | |  | | | | | | |
| Date of last occurrence of behavior(s): | |  | | | | | | |
| Environment(s) where behavior(s) occur: | |  | | | | | | |
| Desired goal/outcome of service: | |  | | | | | | |
| Has the person received the service(s) before? | | | | | | Yes | | No |
| If so, list dates and provider(s) and reason(s) services are provided: | | |  | | | | | |
| Source(s) of Information: | | |  | | | | | |

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| **Support Coordinator Signature/Credentials** |  | **Date** |

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| **❖BIDD Staff Approval❖** |