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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❖** |