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

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| **Name:** |  | **Date of Request:** |
| **Medicaid Number:** |  | **Regional Program:** |
| **Support Coordinator:** | **Phone Number:** |
| **# of Days/Hours Being Requested:** |
| **Diagnoses:** |
| **Current Medications:** |
| **Target Behavior(s):** |
| **Frequency of behavior(s):** | **Date of last occurrence of behavior(s):**  |
| **Environment(s) where behavior(s) occur(red):** |
| **Desired goal/outcome of service:** |
| **Has the person received the service(s) before?** | [ ] **Yes** | [ ] **No** |
| **If so, list dates, provider(s), outcomes/goals achieved and why service ended:** |
| **Source(s) of Information:** |  |

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| **Clinical Supervisor/Credentials** |  | **Date** |

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| **❖BIDD ONLY❖** |
| **Approved** | **Disapproved** |