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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** |