| **ID/DD Waiver Behavior Support****Quarterly Review Report** |
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| **Name:** | **Date of Report:** |  |
| **Medicaid Number:** |
| Behavior Consultant: |  |
| Behavior Specialist: |  |
| Support Coordinator: |
| Behavior Support Plan Approved: |
| Describe any changes in behavior, medication (include prescribing doctor) and/or diagnosis: |  |
| Explain reasons for changes: |  |
| Target Behaviors: |  |
| Locations of Behavior Support Plan implementation:□ Home □ Day Program□ Community□ Place of Employment | Behavior Support Plan structure: □ Modeling □ Reinforcement/Consequences□ Training for staff/family□ One-on-one supervision□ Redirection & blocking□ Verbal Prompting□ Environmental accommodations□ Other: |
| Describe baseline data or data collected for previous review as well as a narrative of the previous review: |
| Include a narrative of the current quarter’s data.  |
| Next Steps: |

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| Behavior Consultant Signature /Credentials |  | Date |