| **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 |