

**Idaho Department of Health and Welfare
Bureau of Developmental Disabilities
Crisis Assistance and Community Crisis Supports Request**

Participant Name:		MID#:	
Provider Agency: Type of Agency:		Staff Requesting: E-mail:	
Start Date of Crisis:	End Date of Crisis:	Total Time Being Requested:	
Service at ER? Yes <input type="checkbox"/> No <input type="checkbox"/>		Is substance abuse involved with the incident? Alcohol <input type="checkbox"/> Drugs <input type="checkbox"/> Both <input type="checkbox"/> None <input type="checkbox"/>	
Current Crisis Situation: (check one)			
<input type="checkbox"/> Loss of housing	<input type="checkbox"/> Family Altercation		
<input type="checkbox"/> Losing employment or income	<input type="checkbox"/> Hospitalization		
<input type="checkbox"/> Incarceration	<input type="checkbox"/> Other Emergency (describe in detail):		
<input type="checkbox"/> Physical harm to self or others			
Presenting Problem:			
Crisis Service Provided: (plan for intervention the resolves crisis):			
Crisis Resolution Plan (What will occur to prevent future crisis?):			
Crisis Hours Authorized <small>(Request should reflect time spent addressing crisis <i>after</i> SC units for month have already been exhausted.)</small>			
G9002 – Crisis Assistance	Units:	Start Date:	End Date:
H2011 – Community Crisis Support	Units:	Start Date:	End Date:
Prior Authorization Number:			
Crisis Hours Denied			
G9002 – Crisis Assistance	Units:		
H2011 – Community Crisis Support	Units:		
Care Manager Signature:	Date:		