



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

Participant Name:		MID#:								
Provider Agency:		Staff Requesting:								
Type of Agency:		E-mail:								
Start Date of Crisis Service:	End Date of Crisis Service:	Total Time Being Requested (Units):								
Service at ER? Yes ☐ No ☐		Is substance abuse involved with the incident? Alcohol ☐ Drugs ☐ Both ☐ None ☐								
Current Crisis Situation: (Check all that apply) <table border="0"><tr><td>☐ Loss of housing</td><td>☐ Family altercation or psychiatric relapse</td></tr><tr><td>☐ Losing employment or income</td><td>☐ Hospitalization or Emergency Room</td></tr><tr><td>☐ Incarceration</td><td></td></tr><tr><td>☐ Physical harm to self or others</td><td></td></tr></table>			☐ Loss of housing	☐ Family altercation or psychiatric relapse	☐ Losing employment or income	☐ Hospitalization or Emergency Room	☐ Incarceration		☐ Physical harm to self or others	
☐ Loss of housing	☐ Family altercation or psychiatric relapse									
☐ Losing employment or income	☐ Hospitalization or Emergency Room									
☐ Incarceration										
☐ Physical harm to self or others										
Presenting Problem:										
Crisis Service Provided: (Explain what services were provided, no other documentation is required for authorization unless requested from the Care Manager for clarification; all supporting documentation must be kept in the participant's medical record.)										
Crisis Resolution Plan: (What will occur to prevent future crisis?):										

<i>For Service Coordination Crisis Assistance request only:</i> All available hours of service coordination have already been provided in the month (4.5 hrs.) IDAPA 16.03.26.630.02 and 16.03.26.630.04. Yes ☐ No ☐			
Crisis Hours Denied			
H2011– Crisis Assistance (Professional SC)		Units:	
H2011 HM – Crisis Assistance (Paraprofessional SC)		Units:	
H2011 – Community Crisis Supports		Units:	
Crisis Hours Authorized (Request should reflect time spent addressing crisis after SC units for month have already been exhausted.)			
H2011– Crisis Assistance (Professional SC)		Units:	Start Date: End Date:
H2011 HM – Crisis Assistance (Paraprofessional SC)		Units:	Start Date: End Date:
H2011 – Community Crisis Supports		Units:	Start Date: End Date:
Crisis Assistance <i>My signature indicates that the information I've provided is accurate and meets crisis assistance guidelines.</i>			
Service Coordinator Professional Signature:		Date:	
Service Coordinator Paraprofessional Signature:		Date:	
Community Crisis Supports <i>My signature indicates that the information I've provided is accurate and meets community crisis support guidelines.</i>			
Requesting Provider Signature:		Date:	
Care Manager Signature:		Approval Date:	

Please complete this form and fax or e-mail the typed form to: Information Coordinator
 Bureau of Developmental Disability Services
 FAX: (208) 332-7297 E-MAIL: BDDACM@dhw.idaho.gov