DD Waiver Services

Thank you for considering Lunsford Behavioral Consulting & Yoga, LLC for your individual's therapeutic consultation needs. Please complete this form to the best of your ability and return it and the other required documents to matthew@lunsfordbehavioralconsulting.com. If any questions or concerns arise during the completion of this form, don't hesitate to contact me.

Date: _____

Client Name: _____ DOB: _____ Age: ___ Sex: _____ Gender: _____
Address: _____
Phone: _____ Email: _____
Medicaid Number: _____ ISP Date: _____ to _____
Waiver Type: _____
Diagnoses: _____

Decision Making
Individual is their own guardian☐
Individual has a legal guardian_☐__
Guardian's Name: _____
Relationship to Individual: _____
Guardian's Address: _____
Guardian's Phone: _____
Guardian's Email: _____

Service Coordination
From which CSB is the individual being referred?
_____

Behavioral Consultation

Please check any interfering behaviors from the categories below by highlighting.

Aggression
__Hitting, biting, etc.
__Inappropriate touching
__Property destruction
__Verbal threats of harm
__Other: _____

Inappropriate Verbal Exchanges
__Negative comments
__Interrupting/Conversation issues
__Profanity in inappropriate places
__Yelling/screaming
__Sexual comments
__Name calling
__Other: _____

Noncompliance
__Leaving designated location
__Leaving property/building
__Verbal/physical refusal of appropriate request
__Failure to comply with safety request
__Other: _____

Self-Injury
__Headbanging
__Using objects to cut or puncture body
__Pinching/Scratching Self
__Purging (self-induced vomiting)
__Intentional food restriction
__Striking self with hand/fist
__Is the individual currently suicidal or homicidal?
__Other: _____

Inappropriate Access to Sensory Needs
__Hygiene Issues
__Bathroom Issues
__Interfering sexual behavior
__Substance Abuse (please specify): _____

Support Coordinator Contact Information

Support Coordinator Name: _____
Office Phone: _____ Cell Phone: _____
Email: _____ Fax: _____

If applicable, please complete the following:

Group Home/Other
Contact Name_____
Office Phone_____
Cell Phone_____
Email_____
Fax_____

Day Support
Contact Name_____
Office Phone_____
Cell Phone_____
Email_____
Fax_____

Please describe the problem behaviors in detail below.

1. _____
   _____
   _____
2. _____
   _____
   _____

Please make sure the following documents are submitted with your referral. If a document isn't applicable to the individual's case, please indicate as such when you email me.

__Intake Questionnaire – Required
__Annual Risk Assessment (RAT) – Required
__ SIS – Required
__Psychological Evaluation
__Other: _____