- ❑ Initiate Waiver services
- ❑ Service Modification
  - ☐ Add a service
  - ☐ Increasing hours of service
  - ☐ Decreasing hours of service
- ❑ Change in SF (requires 2 ISARs)
- ❑ End CD Service

MR/ID Waiver
Consumer-Directed Companion Services
Individual Service Authorization Request

CSB _____

CSB provider # _____

Name: _____ Medicaid No. _____
Last, First MI

Address: _____
Street/Apt. City, State Zip Code

Phone No. _____ SF E-mail Address: _____

Services Facilitator (SF) _____ Provider No. _____
SF agency, if applicable _____ Individual is 18 or older Yes ____ No ____

Will the individual be directing his or her own services? ☐ Yes ☐ No	If NO, name and relationship of responsible family member/caregiver:

SERVICE REQUESTED	WEEKLY / MONTHLY HOURS	ODS USE ONLY
Fill in applicable dates: **CD Companion** services start date may not precede: SF Start Date: _____ SF End Date: _____ S5136--CD Companion Start Date: _____ S5136--CD Companion End Date: _____ Total # of persons with disabilities in the residence_____	_____ Hours / week x 4.6 = _____ Monthly total	

Reason for this request: _____

Check the allowable activities included in the individual's PFS. Indicate the *total* number of hours *per day* of expected CD Companion services.

Support with	**Sun**	**Mon**	**Tue**	**Wed**	**Thur**	**Fri**	**Sat**
☐ tasks such as meal preparation, laundry and shopping							
☐ light housekeeping tasks							
☐ self-administration of medication							
☐ community access and social/recreational activities							
☐ assuring the safety of the individual							

Comments:

List any other currently authorized AD or CD Companion services providers:

Assurance that total of all AD and CD Companion services hours does not exceed 8 hrs in any 24hr. period. ☐ yes ☐ no

Signature of Services Facilitator _____ Date _____

I agree that the above plan for supports is appropriate to the identified needs of this individual. This PFS has been approved by the individual and included in the ISP maintained in the Support Coordinator's/Case Manager's record.

CSB Rep/Supp. Coord./Case Manager (print) _____ Phone No. _____ Fax No. _____

Signature _____ Date _____