❑ 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 Respite
Individual Service Authorization Request

CSB _____

CSB provider # _____

Name: _____ Medicaid No. _____
Last, First MI

Address:_____
Street/Apt City, State Zip Code

Phone No._____

Services Facilitator (SF)_____ Provider No. _____

SF agency, if applicable_____ SF E-mail Address: _____

Will the individual be directing his or her own services? ☐ Yes ☐ No

If NO, name and relationship of responsible family member/caregiver:

SERVICE TO BE PROVIDED	YEARLY HOURS NEEDED	ODS USE ONLY
Fill in applicable dates: **CD Respite** services start date may not precede: SF Start Date:_____ SF End Date: _____ S5150--CD Respite Start Date: _____ S5150--CD Respite End Date: _____		

Reason for this request: _____

Not available to individuals living with paid caregivers. Maximum is 720 hours per calendar year **(maximum = 360 hours between 1/1/11 and 6/30/11),** including agency-directed.
Check the allowable activities included in the individual's ISP.

Support with
☐ activities of daily living
☐ monitoring health status & physical condition
☐ self-medication and/or other medical needs
☐ meal preparation and eating
☐ housekeeping activities
☐ participating in social/recreational/community activities
☐ appointments or meetings
☐ bowel/bladder programs, range of motion exercises, routine wound care (per MD's orders and RN oversight)
☐ assuring the safety of the individual

Training for assistant
☐ as requested by the individual or caregiver that relates to services described in the PFS

Comments:

If applicable, list any current or previously authorized Respite providers and total number of hours used since January of this year:_____ (Hrs. used)

Signature of 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/Support Coordinator/Case Manager (print) Phone No. Fax No.

Signature Date