

- Initiate Waiver services
- Service Modification
 - Add a service
 - Increasing hours of service
 - Decreasing hours of service
- Provider Modification (requires 2 ISARs)
- End a service

CSB _____

CSB provider # _____

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

Provider Name _____ Provider E-mail address _____ Provider Number _____

Name: Last, First MI Start: Date End: Date

Medicaid Number: _____

SERVICE TO BE PROVIDED	WEEKLY / MONTHLY HOURS	ODS USE ONLY
Companion – S5135	<div style="border-bottom: 1px solid black; width: 100px; margin: 0 auto;"></div> Hours / week x 4.6 = <div style="border-bottom: 1px solid black; width: 100px; margin: 0 auto;"></div> Monthly total	

Reason for the request: _____

Answer the questions and check the allowable activities included in the individual's plan. Indicate the *total* number of hours per day. Companion Services is limited to 8 hours per day.

Is there a therapeutic goal in the PFS as required? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is the individual age 18 or older? <input type="checkbox"/> Yes <input type="checkbox"/> No														
Support with <input type="checkbox"/> tasks such as meal preparation, laundry, shopping <input type="checkbox"/> light housekeeping tasks <input type="checkbox"/> self-administration of medication <input type="checkbox"/> community access & social/recreational activities <input type="checkbox"/> assuring the safety of the individual	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 12.5%;">Sun</th> <th style="width: 12.5%;">Mon</th> <th style="width: 12.5%;">Tue</th> <th style="width: 12.5%;">Wed</th> <th style="width: 12.5%;">Thur</th> <th style="width: 12.5%;">Fri</th> <th style="width: 12.5%;">Sat</th> </tr> </thead> <tbody> <tr style="height: 40px;"> <td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </tbody> </table>	Sun	Mon	Tue	Wed	Thur	Fri	Sat							
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Comments: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>															

Name of Provider Agency Representative (print) _____ Signature _____ 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) _____ Signature _____ Phone No. _____ Fax No. _____ Date _____