

- 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
Personal Assistance
Individual Service Authorization Request**

| | | |
|---------------|-------------------------|-----------------|
| Provider Name | Provider E-mail address | Provider Number |
| Name: _____ | Start: _____ | End: _____ |
| Last, | First | MI |
| _____ | _____ | _____ |
| _____ | Date | Date |

Medicaid Number: _____

| SERVICE TO BE PROVIDED | WEEKLY / MONTHLY HOURS | | ODS USE ONLY |
|---|---|----------------|---|
| Personal Assistance – T1019 Total # of persons with disabilities in same residence: _____ | $\frac{\text{Hours / week}}{\text{_____}}$ | $\times 4.6 =$ | $\frac{\text{Monthly total (A)}}{\text{_____}}$ |
| Enter periodic support hours per month if needed – Do not include in daily hours below. | $\frac{\text{Hours / month}}{\text{_____}}$ | $+ (A) =$ | $\frac{\text{Monthly total (B)}}{\text{_____}}$ |

Reason for the request: _____

| Does the individual need training and skills development? <input type="checkbox"/> Yes <input type="checkbox"/> No | If Yes, in what other service or program is the training and skills development received? _____ | | | | | | | | | | | | | | |
|--|--|-----|-----|------|-----|------|-----|-----|--|--|--|--|--|--|--|
| Answer the questions and check the allowable activities below. | Indicate hours per/day. | | | | | | | | | | | | | | |
| Support with <input type="checkbox"/> activities of daily living (Must be included to receive service) <input type="checkbox"/> monitoring health status & physical condition <input type="checkbox"/> medication and/or other medical needs <input type="checkbox"/> meal preparation and eating <input type="checkbox"/> housekeeping activities <input type="checkbox"/> participating in social/recreational/community activities <input type="checkbox"/> appointments or meetings <input type="checkbox"/> bowel/bladder programs, range of motion exercises, routine wound care (per MD's orders and RN oversight) <input type="checkbox"/> assuring the safety of the individual <input type="checkbox"/> activities in the workplace or post-secondary school (does not duplicate ADA or SE services) | <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th>Sun</th> <th>Mon</th> <th>Tue</th> <th>Wed</th> <th>Thur</th> <th>Fri</th> <th>Sat</th> </tr> </thead> <tbody> <tr> <td style="height: 100px;"></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table> | Sun | Mon | Tue | Wed | Thur | Fri | Sat | | | | | | | |
| Sun | Mon | Tue | Wed | Thur | Fri | Sat | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| Comments: _____ _____ | | | | | | | | | | | | | | | |

| | | |
|--|-----------|------|
| Name of Provider Agency Representative (print) | Signature | Date |
| <i>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.</i> | | |

| | | | | |
|--|-----------|-----------|---------|------|
| CSB Rep/Supp. Coord./Case Mgr. (print) | Signature | Phone No. | Fax No. | Date |
|--|-----------|-----------|---------|------|