

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

MR/ID Waiver Agency-Directed Respite Individual Service Authorization Request

CSB _____

CSB provider # _____

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

Medicaid Number: _____

SERVICE TO BE PROVIDED	YEARLY HOURS NEEDED	ODS USE ONLY
T1005 Respite <input type="checkbox"/> In-Home <input type="checkbox"/> Center-Based <input type="checkbox"/> Out-of-Home <input type="checkbox"/> Residential		

Total AD and/or CD Respite Hours used this calendar year: _____

Reason for this request: _____

Check the allowable activities that are included in the PFS:

Not available to individuals living with paid caregivers; cannot be provided by Foster/Family Care providers to their own resident. Maximum 720 Respite hours per calendar year (**maximum = 360 hours between 1/1/11 and 6/30/11**), including CD Respite.

Support with:

- activities of daily living
- monitoring health status & physical condition
- medication and/or other medical needs
- meal preparation & 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

Comments: _____

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 _____