

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

MR/ID Waiver Environmental Modification Individual Service Authorization Request

CSB _____

CSB provider # _____

Provider Name: _____ Provider E-mail Address: _____ Provider Number: _____
(if Medicaid provider number is assigned)

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

Medicaid No. _____ The individual must have at least one other MR/ID Waiver service to receive this service.

CHECK SERVICE TO BE PROVIDED	COST	OMR USE ONLY
<input type="checkbox"/> S5165 Environmental Mod; modifications only		
<input type="checkbox"/> 99199 U4 Environmental Mod; Maintenance cost only		

Maximum Expenses = \$5,000 per ISP year/**calendar year** – effective 1/1/11

Note previous expenses this ISP/calendar yr: _____

Is the owner of the residence required to make reasonable accommodations according to the Americans with Disabilities Act, Virginians with Disabilities Act & the Rehabilitation Act? Yes No

Reason for this request: _____

Check the following as needed by the individual:

- Physical adaptation of a house or place of residence necessary to assure an individual's health & safety (*excluding living arrangements that are owned or leased by providers of waiver services*)
- Physical adaptation of a house or place of residence which enable an individual to live in a non-institutional setting and to function with greater independence (*excluding living arrangements that are owned or leased by providers of waiver services*)
- Modification to the individual's primary vehicle (*excluding vehicles that are owned or leased by paid providers of waiver services*)
- Rehabilitation Engineering (reason needed): _____

Describe the specific modifications, equipment, supplies and/or other services to be provided:

Comments: _____

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 Case Manager's record.

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