

- 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 Crisis Stabilization Individual Service Authorization Request

CSB _____
CSB provider # _____

Provider Name	Provider E-mail Address	Provider Number
Name: _____	Start: _____	End: _____
Last	First	MI
Medicaid Number: _____		Date

CHECK SERVICE TO BE PROVIDED	HOURS NEEDED	ODS USE ONLY
<input type="checkbox"/> H2011 Crisis Stabilization (Clinical/Behavioral Intervention) [15 day limit; maximum 60 days in calendar yr]		
<input type="checkbox"/> H0040 Crisis Supervision [allowable only if H2011 is provided]		
► Provider (if different):		
Name: _____		
Number: _____		

Days used this calendar year: _____

Reason for this request: _____

Documentation in the record indicates the individual: (Check all that apply; must meet at least one)

- is experiencing marked reduction in psychiatric, adaptive or behavioral functioning
- is experiencing extreme increase in emotional distress
- needs continuous intervention to maintain stability
- is causing harm to self or others

The individual is at risk of: (Check all that apply; must meet at least one)

- psychiatric hospitalization
- emergency ICF/MR placement
- immediate threat of loss of a community service due to a severe situational reaction (e.g., change in schedule/staff/medication)
- causing harm to self or others

A face-to-face assessment reassessment was completed by a qmrp:

Name	Agency	Date
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A Plan for Supports outlining the specific activities of professionals and staff:

- has been received by the support coordinator/case manager.
- will be received within 72 hours of the assessment/reassessment by the qmrp.

Individual's Name:

Last

First

MI

Check the following allowable activities included in the PFS:

- Psychiatric, neuropsychiatric, psychological assessment & other assessments & stabilization techniques
- Medication management & monitoring
- Behavior assessment & positive behavior support
- Intensive care coordination with other agencies/providers to assist in planning & delivery of services & supports to enable the individual to remain in the community
- Training of family members, other care givers & service providers in positive behavioral supports to maintain the individual in the community

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- Temporary crisis supervision to ensure the safety of the individual and others

Comments: _____

Name of Provider Agency Representative/Clinical Intervention (print)

Signature

Date

Name of Provider Agency Representative/ Crisis Supervision (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