

- Initiate Waiver services
- Service Modification
 - Add a service
 - Increasing hours of service
 - Decreasing hours of service
 - Procedure code modification
(requires 2 ISAR's)
- Provider Modification (requires 2 ISARs)
- End a service

MR/ID Waiver Supported Employment 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: _____

| CHECK SERVICE TO BE PROVIDED | WEEKLY / MONTHLY HOURS OR BLOCKS | ODS USE ONLY |
|--|--|--------------|
| <input type="checkbox"/> H2023 Supported Emp, Individual | _____ x 4.6 = _____ Hours / week Monthly total | |
| <input type="checkbox"/> H2024 Supported Emp., Group | _____ x 4.6 = _____ Blocks / week Monthly total | |

Reason for this request: _____

Check the allowable activities that are included in the PFS:

- Individualized assessment & development of employment related goals
- Individualized job development
- On-the-job training in work & work-related skills required to perform the job
- Ongoing evaluation, supervision and monitoring of job performance beyond supervisor's responsibilities
- Ongoing supports necessary to assure job retention
- Development of related skills essential to obtaining & retaining employment
- Safety Supports to ensure health and safety
- Travel with the individual to and from work sites, when other travel assistance unavailable
- Other:

There is documentation in the record that Supported Employment Services cannot be obtained from the school system (for those less than 22 years) nor from Department of Rehabilitative Services? Yes No

| Record the number of hours per day of the following: <i>(for biweekly/ varied schedules, draw a line to indicate different weeks)</i> | SUN | MON | TUES | WED | THU | FRI | SAT |
|--|-----|-----|------|-----|-----|-----|-----|
| Total Hours of Service Time <i>(e.g., if individual is in services from 8 a.m. until noon, enter "4")</i> | | | | | | | |
| Travel with the individual to & from program: <i>[record if billing for this time; can be included up to 25% of the total time; to bill for a 3-block day, a minimum of 7 hrs of other allowable activities is required; does not include skill building-related travel in scheduled activities]</i> | | | | | | | |

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 _____