

- 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 Residential Support 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: _____	WEEKLY / MONTHLY HOURS	ODS USE
CHECK SERVICE TO BE PROVIDED ONLY		

<input type="checkbox"/> H2014 In-Home Total # of persons with disabilities living in same residence: _____ <input type="checkbox"/> 97535 Congregate (please specify below) Total # of persons with disabilities living in same residence: _____ <input type="checkbox"/> Group Home <input type="checkbox"/> Group Home for Children <input type="checkbox"/> Adult Foster Care Home <input type="checkbox"/> Sponsored Residential <input type="checkbox"/> Other: _____	<hr/> Hours / week x 4.6 = Monthly total (1)	
Enter periodic support hours per month if needed—Do not include in daily hours below. Enter total of periodic support hours + regular hours per month →	<hr/> Hours / week x 4.3 = Monthly total (1)	
	<hr/> Hours / month + (1) = Monthly total (2)	

Reason for this request: _____

Check the allowable activities that are included in the PFS. Indicate the *total* number of hours of support time per day.

	Sun	Mon	Tues	Wed	Thur	Fri	Sat
Skill Building related to <input type="checkbox"/> personal care <input type="checkbox"/> activities of daily living <input type="checkbox"/> use of community resources <input type="checkbox"/> positive behaviors for home and community environments							
Supports with <input type="checkbox"/> personal care <input type="checkbox"/> activities of daily living <input type="checkbox"/> use of community resources <input type="checkbox"/> positive behaviors for home and community environments <input type="checkbox"/> medication, medical needs, monitoring health & physical condition <input type="checkbox"/> travel to and from community sites & resources							
Safety Supports with <input type="checkbox"/> health & safety							
<input type="checkbox"/> Nighttime Safety Supports -- If applicable, indicate hours needed and provide explanation:							
What will staff do for Nighttime Safety Supports ?							
TOTAL DAILY HOURS (Skill Building/Supports + Nighttime Safety Supports)							

ATTACH ADDITIONAL PAGES IF FURTHER EXPLANATION IS NEEDED.

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 Manager (print)	Signature	Phone No. Fax No. Date