

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

MR/ID Waiver Skilled Nursing Services 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			ODS USE ONLY
<input type="checkbox"/> T1002 Skilled Nursing – RN	Weekly Hours	x 4.6 =	Monthly total (1)	
<input type="checkbox"/> T1003 Skilled Nursing – LPN	Weekly Hours	x 4.6 =	Monthly total (1)	
			+	
Enter estimated periodic support hours per month, if needed →			Monthly PSH Hours*	
			=	
Enter total of estimated periodic support hours + regular hours per month →			Monthly total (2)*	

Reason for this request: _____

Must submit documentation of medical necessity by a physician. Note: Short term skilled nursing needs should be covered under the Medicaid State Plan.

*Periodic Support Hours may only be billed when provided according to a justifiable, documented reason.

Check the allowable activities included in the Plan for Supports:

- Monitoring individual's medical status
- Administering medication or other medical treatment
- Training, consultation, nurse delegation or oversight of family members, staff or others to monitor individual's medical status
- Training, consultation, nurse delegation or oversight of family members, staff or others to administer medications
- Training, consultation, nurse delegation or oversight of family members, staff or others to perform medically related procedures

Comments: _____

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 Individual Support Plan maintained in the Support Coordinator's/Case Manager's record.</i>		
CSB Rep/Support Coord./Case Mgr. (print)	Signature	Phone No. Fax No. Date