

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

**MR/ID Waiver
Personal Emergency Response System
Individual Service Authorization Request**

CSB _____

CSB provider # _____

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

CHECK SERVICE TO BE PROVIDED	AMOUNT REQUESTED	ODS USE ONLY
<input type="checkbox"/> S5160 - Personal Emergency Response System Installation		
<input type="checkbox"/> S5160 U1 - PERS & Medication Monitoring Installation		
<input type="checkbox"/> S5185 - PERS & Medication Monitoring (physician ordered)	_____ mos/year	
<input type="checkbox"/> S5161 - PERS Monitoring	_____ mos/year	
<input type="checkbox"/> H2021 TD - PERS Nursing Services (RN)	_____ X .5hr = ___hrs/wk	
<input type="checkbox"/> H2021 TE - PERS Nursing Services (LPN)	_____ X .5hr = ___hrs/wk	

Reason for this request

Individual lives alone/is alone for significant parts of the day: ___ YES ___ NO

Check the following regarding the PERS:

- Capable of being activated by a remote wireless device and being connected to the individual's phone line.
- Provides hands-free voice-to-voice communication with the response center.
- Activating device is waterproof, automatically transmits to the response center, signals low battery and can be worn by the individual
- Will be tested at least monthly to assure remains operational
- The PERS provider agrees to instruct the individual, family, caregiver and responders as described below:

Additional information:

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 Support Coordinator's/Case Manager's record.

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