

- 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 Therapeutic Consultation 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: _____ Only Behavioral Consultation may be provided in the absence of other MR/ID Waiver services.

CHECK SERVICE TO BE PROVIDED	HOURS NEEDED	ODS USE ONLY
_____ 97139 Therapeutic Consultation <input type="checkbox"/> Behavioral <input type="checkbox"/> Psychological <input type="checkbox"/> Speech <input type="checkbox"/> Occupational <input type="checkbox"/> Physical <input type="checkbox"/> Recreational <input type="checkbox"/> Rehabilitation Engineering		

Reason for this request:

Check the allowable activities that are included in the PFS. Indicate the total number of hours for each section below:

(May not be direct therapy, evaluations, or services available through the Medicaid State Plan.)	Hours needed in each area
Assessment/evaluation: <input type="checkbox"/> interviewing to identify issues to be addressed/desired outcomes <input type="checkbox"/> observing in daily activities and natural environments <input type="checkbox"/> assessing need for assistive device or modification/adjustment in environment or services <input type="checkbox"/> developing data collection mechanisms and collecting baseline data <input type="checkbox"/> observing & assessing current interventions, support strategies, or assistive devices <input type="checkbox"/> reviewing documentation & evaluating efficacy of assistive device or interventions suggested	
Training, consultation & technical assistance to program staff/family: <input type="checkbox"/> training in better supporting the individual through enhanced observations of environment/routines/interactions <input type="checkbox"/> reviewing documentation & evaluating staff/family activities <input type="checkbox"/> demonstrating/training in specialized therapeutic interventions or use of assistive devices	
Assistance in design & integration of individual objectives as part of the overall individual program planning process: <input type="checkbox"/> designing & developing a written Support Plan <input type="checkbox"/> making recommendations related to specific devices/technology or adapting other training programs/activities	

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 CSP maintained in the Case Manager's record.

CSB Rep/ Case Manager (print) _____ Signature _____ Phone No. _____ Fax No. _____ Date _____