

- Initiate Waiver service
- Service Modification (add a service)
- Increase or decrease units/hours of service
- Provider Modification (requires 2 ISARs)
- Procedure Code Modification (requires 2 ISARs)
- End a service

MR/ID Waiver 60-Day Assessment 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 / BLOCKS	ODS USE ONLY
<input type="checkbox"/> H2014 In-Home Total # of persons with disabilities in residence: _____	Weekly Hours x 4.6 = Monthly Total 1	
<input type="checkbox"/> 97535 Congregate (please specify below)—Total # of persons with disabilities in residence: _____ <input type="checkbox"/> Group Home <input type="checkbox"/> Group Home for Children <input type="checkbox"/> Adult Foster Care Home <input type="checkbox"/> Other: <input type="checkbox"/> Sponsored Residential	Weekly Hours x 4.3 = Monthly Total 1	
<input type="checkbox"/> T1019 Personal Assistance—Total # of persons with disabilities in residence: _____	Weekly Hours x 4.6 = Monthly Total 1	
<input type="checkbox"/> 97537 DS Reg. Int. Center-Based or Non-Center-Based <input type="checkbox"/> 97537 U1 DS High Int. Center-Based or Non-Center-Based <input type="checkbox"/> H2025 PREVOC Reg. Intensity <input type="checkbox"/> H2025 U1 PREVOC High Intensity <input type="checkbox"/> Check this box to verify meeting at least 1 of the criteria if requesting high intensity service above.	Weekly Blocks x 4.6 = Monthly Total 1	
Enter Periodic Support hours/blocks per month if needed – RS, PA, DS & PV only. Do not include in hours per day below.		Monthly Total
Enter TOTAL of Periodic Support hours/blocks + regular hours/blocks per month.		Monthly Total 2
<input type="checkbox"/> H2023 Supported Employment, Individual Placement	Weekly Hours x 4.6 = Monthly Total	
<input type="checkbox"/> H2024 Supported Employment, Group	Weekly Blocks x 4.6 = Monthly Total	

While providing the agreed-upon supports, a 60-day assessment must be used to 1) evaluate the individual's needs and interests in the service environment and community settings and 2) develop an annual service plan. Why is this assessment period needed for this individual?

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

Assessment of and supports with:	Sun	Mon	Tues	Wed	Thur	Fri	Sat
<input type="checkbox"/> participation in a variety of settings and activities							
<input type="checkbox"/> all life skill areas related to the service, including identification of personal preferences							
<input type="checkbox"/> health and safety issues							
<input type="checkbox"/> needs for nighttime safety supports (Residential only)—Provide explanation and what staff will do.							
Travel with the individual to and from DS/SE/PREVOC program: (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)							

ATTACH ADDITIONAL PAGES IF FURTHER EXPLANATION IS NEEDED.

We, the undersigned, assure that the assessment PFS will be followed by the development and implementation of an annual PFS (approved by the individual) by the end of the 60-day period.

Name of Provider Agency Representative (print)	Signature	Date
--	-----------	------

In addition to the assurance above, I agree that the assessment 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 Mgr. (print

Signature

Phone No.

Fax No.

Date