

DAY SUPPORT WAIVER

Day Support Individual Service Authorization Request

CSB _____
CSB provider # _____

- Initiate Waiver services
- Service Modification
 - Increase units/hours of service
 - Decrease units/hours of service
 - Procedure code modification (requires 2 ISARs)
- ISARs)
 - Provider modification (requires 2 ISARs)

Provider Name	Provider E-mail Address	Provider No.
Name: _____	Start: _____	End: _____
Last,	First	MI
		Date
		Date

Medicaid Number: _____
 CHECK SERVICE TO BE PROVIDED WEEKLY / MONTHLY BLOCKS ODS USE
 ONLY

<input type="checkbox"/> 97537 Day Support, Reg Int. Center Based					
<input type="checkbox"/> 97537 U1 Day Support, High Int. Center Based					
<input type="checkbox"/> 97537 Day Support, Reg Int. Non Center					
<input type="checkbox"/> 97537 U1 Day Support, High Int. Non Center	Blocks/week	x 4.6 =	Monthly Total 1		
			+		
Enter Periodic Support blocks per month if needed – Do not include in hours/day below.	→		Monthly Total		
			=		
Enter TOTAL of Periodic Support blocks + regular blocks per month.	→		Monthly Total 2		

Reason for this request:

If High Intensity, check which criteria are met:

- | | |
|--|--|
| <input type="checkbox"/> Requires physical assistance to meet basic personal care needs
<input type="checkbox"/> Has extensive disability-related difficulties and requires additional, ongoing support to fully participate in services and to accomplish desired outcomes | <input type="checkbox"/> Requires extensive personal care and/or constant supports to reduce or eliminate behaviors which preclude full participation in services. [A formal, written support activity or behavior plan is required to address challenging behaviors.] |
|--|--|

Check the allowable activities that are included in the PFS:

- | | |
|---|--|
| Skill building
<input type="checkbox"/> self, social, environmental awareness
<input type="checkbox"/> sensory, gross/fine motor skills
<input type="checkbox"/> communication skills
<input type="checkbox"/> social skills
Safety Supports
<input type="checkbox"/> to ensure health and safety | <input type="checkbox"/> personal care
<input type="checkbox"/> use of community resources, community safety
<input type="checkbox"/> problem solving
<input type="checkbox"/> positive behavior & interactions
<input type="checkbox"/> social and community settings |
|---|--|

- Support**
- | | |
|---|---|
| <input type="checkbox"/> personal care tasks
<input type="checkbox"/> use of community resources | <input type="checkbox"/> travel between service activity sites
<input type="checkbox"/> opportunities to use developing skills in community settings |
|---|---|

Record the number of hours per day of the following: <i>(for biweekly/ varied schedules, draw a line to indicate different weeks)</i>	SUN	MON	TUES	WED	THU	FRI	SAT
Total Hours of Service Time <i>(e.g., if individual is in service from 8 a.m. until noon, enter "4")</i>							
Travel with the individual to & from program: <i>[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]</i>							

ATTACH ADDITIONAL PAGES IF FURTHER EXPLANATION IS NEEDED.

Name of Provider Agency Representative (print)	Signature	Date
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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./Case Manager (print)	Signature	Phone No.	Fax No.	Date
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