

- Initiate Waiver services
- Service Modification
  - Add a service
  - Increase units/hours of service
  - Decrease units/hours of service
  - Procedure code modification (requires 2 ISAR's)
- Provider modification (requires 2 ISARs)
- End a service

# DAY SUPPORT WAIVER

## Prevocational Services Individual Service Authorization Request

CSB \_\_\_\_\_  
CSB provider # \_\_\_\_\_

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

Medicaid Number: \_\_\_\_\_

CHECK SERVICE TO BE PROVIDED ONLY WEEKLY / MONTHLY BLOCKS ODS USE

<input type="checkbox"/> H2025 Prevocational, Reg Int. Center Based				
<input type="checkbox"/> H2025 U1 Prevocational, High Int. Center Based				
<input type="checkbox"/> H2025 Prevocational, Reg Int. Non Center Based				
<input type="checkbox"/> H2025 U1 Prevocational, High Int. Non Center Based	Blocks/week	x 4.6 =	Monthly Total 1	
				+
Enter <b>Periodic Support</b> blocks per month if needed – Do not include in hours per day below.	→		Monthly Total	
				=
Enter <b>TOTAL</b> 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.]
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**Check the allowable activities that are included in the PFS:**

<b>Skill building</b> <input type="checkbox"/> developing skills required for paid employment or volunteer work in community settings <b>Safety Supports</b> <input type="checkbox"/> to ensure the individual's health and safety	<b>Support</b> <input type="checkbox"/> with personal care tasks <input type="checkbox"/> travel between service activity sites
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**There is documentation in the record that Prevocational Services cannot be obtained from the school system (for those less than 22 years) nor from Department of Rehabilitative Services?**  Yes  No

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

*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