

- 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

DAY SUPPORT 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 _____

Medicaid Number: _____

CHECK SERVICE TO BE PROVIDED	WEEKLY / MONTHLY BLOCKS	ODS USE ONLY
<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	Weekly Blocks 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
<input type="checkbox"/> H2023 Supported Employment, Individual	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?

<p>If High Intensity, check which criteria are met:</p> <p><input type="checkbox"/> Requires physical assistance to meet basic personal care needs</p> <p><input type="checkbox"/> Has extensive disability-related difficulties and requires additional, ongoing support to fully participate in services and to accomplish desired outcomes</p>	<p><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.]</p>
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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	Thur	Fri	Sat
<p>Assessment of and support with:</p> <p>Check the allowable activities that are included in the PFS.</p> <p><input type="checkbox"/> participation in a variety of settings and activities</p> <p><input type="checkbox"/> all life skill areas related to the service, including identification of personal preferences</p> <p><input type="checkbox"/> health and safety issues</p>							
<p>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)</p>							

ATTACH ADDITIONAL PAGES IF FURTHER EXPLANATION IS NEEDED.

We, the undersigned, assure 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.

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