❑ Initiate Waiver service
❑ Service Modification (add a service)
❑ Provider Modification (requires 2 ISARs)
❑ End a service

MR Waiver 60-Day Assessment
Individual Service Authorization Request

CSB _____

CSB provider #

_____

Provider Name _____ Provider Number _____

Name: _____ Start: _____ End: _____

Last, First MI — Date — Date

Medicaid Number: _____

CHECK SERVICE TO BE PROVIDED ONLY	WEEKLY / YEARLY HOURS / UNITS	OMR USE
☐ Z8595 Supported Living / In-Home	_____ Weekly Hours x 52 = _____ Yearly Hours	
☐ Z8551 Congregate (please specify below) ☐Group Home ☐Group Home for Children ☐Adult Foster Care Home ☐Assisted Living Facility ☐Sponsored Placement ☐Other:	_____ Weekly Hours x 52 = _____ Yearly Hours	
☐ Z4036 Personal Assistance	_____ Weekly Hours x 52 = _____ Yearly Hours	
Enter periodic support hours *per week* (if needed)—RS and PA only.	_____ Weekly Hours	
Enter total of periodic support hours + regular hours per week	_____ Weekly Hours x 52 = _____ Yearly Hours	
☐ Z8556 DS or ☐PREVOC Reg. Int. Center-Based ☐ Z8557 DS or ☐PREVOC High Int. Center-Based ☐ Z8560 DS or ☐PREVOC Reg. Int. Non-Center-Based ☐ Z8561 DS or ☐PREVOC High Int. Non-Center-Based	_____ Weekly Units x 52 = _____ Yearly Units	
☐ Z8597 Supported Employment, Individual Placement	_____ Weekly Hours x 52 = _____ Yearly Hours	
☐ Z8598 Supported Employment, Enclave/Work Crew	_____ Weekly Units x 52 = _____ Yearly Units	

While providing the agreed-upon supports and services, 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 plan. Indicate the *total* number of hours per day:

Assessment of and assistance with: ☐ participation in a variety of settings and activities ☐ all life skill areas related to the service, including identification of personal preferences ☐ health and safety issues	**Sun**	**Mon**	**Tues**	**Wed**	**Thur**	**Fri**	**Sat**
☐ needs for nighttime specialized supervision (residential only)							
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-unit day, a minimum of 7 hrs of other allowable activities is required; does not include training related travel in scheduled activities)							

ATTACH ADDITIONAL PAGES IF FURTHER EXPLANATION IS NEEDED.

We, the undersigned, assure that the assessment ISP will be followed by the development and implementation of an annual ISP (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 of services is appropriate to the identified needs of this individual. This service plan 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

- ❑ Initiate Waiver services
- ❑ Service Modification
  - € Add a service
  - € Increasing level/hours of service
  - € Decreasing level/hours of service
- ❑ Provider Modification (requires 2 ISARs)
- ❑ End a service

MR Waiver Assistive Technology
Individual Service Authorization Request

CSB _____

CSB provider #

_____

Provider Name _____ Provider Number _____

Name: _____ Start: _____ End: _____

Last, First MI Date Date

Medicaid Number: _____

The individual must have at least one other MR Waiver service to receive this service.

CHECK SERVICE TO BE PROVIDED	COST	OMR USE ONLY
☐ Z8603 Assistive Technology; Rehab Engineer		
☐ Z8604 Assistive Technology; Off Shelf Item		
☐ Z8605 Assistive Technology; Supply Cost		

Maximum Expenses = $5,000 per CSP year Note previous expenses this CSP yr: _____

Reason for this request (attach documentation of recommendation by a qualified professional)

Have any of the following been requested and denied under Medicaid SPO Durable Medical Equipment? ☐ Yes ☐ No
Explain:

Check the following as needed by the individual:
- ☐ Specialized medical equipment and ancillary equipment/supplies necessary for life support
- ☐ Durable/non-durable medical equipment and supplies
- ☐ Adaptive devices, appliances, and/or controls which enable an individual to be more independent in activities of daily living
- ☐ Equipment and devices which enable an individual to communicate more effectively
- ☐ Rehabilitation Engineering (reason needed:) _____

Describe the specific modifications, equipment, supplies and/or other services to be provided:

Comments:

I agree that the above plan of services is appropriate to the identified needs of this individual. This service plan 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

- ❑ Initiate Waiver services
- ❑ Service Modification
  - € Add a service
  - € Increasing level/hours of service
  - € Decreasing level/hours of service
- ❑ Provider Modification (requires 2 ISARs)
- ❑ End a service

MR Waiver
Consumer-Directed Companion Services
Individual Service Authorization Request

CSB _____

CSB provider #

_____

Name: _____ Medicaid No. _____
Last, First MI

_____ _____ _____ Reassessment? Y__ N__
Service Facilitator (SF) Provider No. SF Start Date

SF agency, if applicable _____ CD Companion _____

Will the individual be directing his or her own services? ☐ Yes ☐ No	If NO, name and relationship of responsible family caregiver:

SERVICE TO BE PROVIDED	WEEKLY / YEARLY HOURS	OMR USE ONLY
CD Companion Services Start Date _____	_____ Hours / week x 52 = _____ Yearly total (1)	

Reason for this request: _____

Check the allowable activities included in the individual's ISP. Indicate the *total* number of hours *per day* of expected CD Companion services. Companion services cannot exceed a total of eight hours per day per individual.

Assistance or support with	**Sun**	**Mon**	**Tue**	**Wed**	**Thur**	**Fri**	**Sat**
☐ tasks such as meal preparation, laundry and shopping							
☐ light housekeeping tasks							
☐ self-administration of medication							
☐ community access and recreational activities							
☐ health and safety							

Comments:

List any other currently authorized Companion services providers and hours:

_____ _____
Signature of Services Facilitator Date

I agree that the above plan of services is appropriate to the identified needs of this individual. This service plan has been approved by the individual and included in the CSP maintained in the Case Manager's record.

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

_____ _____
Signature Date

- ❑ Initiate Waiver services
- ❑ Service Modification
  - € Add a service
  - € Increasing level/hours of service
  - € Decreasing level/hours of service
- ❑ Provider Modification (requires 2 ISARs)
- ❑ End a service

MR Waiver
Consumer-Directed Personal Assistance
Individual Service Authorization Request

CSB _____

CSB provider #

_____

Name: _____ Medicaid No. _____
Last, First MI

_____ _____ _____ Reassessment? Y__ N__
Services Facilitator (SF) Provider No. SF Start Date

SF agency, if applicable _____ CD Assistant _____

Will the individual be directing his or her own services? ☐ Yes ☐ No	If NO, name and relationship of responsible family caregiver:

SERVICE TO BE PROVIDED	WEEKLY / YEARLY HOURS	OMR USE ONLY
CD Personal Assistance – Y0078 Start Date _____	_____ Hours / week x 52 = _____ Yearly total (1)	

Reason for this request: _____

Check the allowable activities included in the individual's ISP. Indicate the *total* number of hours per day of CD PA.

Assistance with	**Sun**	**Mon**	**Tue**	**Wed**	**Thur**	**Fri**	**Sat**
☐ activities of daily living ***(Must need to receive PA)***							
☐ monitoring health status & physical condition							
☐ self-medication and/or other medical needs							
☐ meal preparation and eating							
☐ housekeeping activities							
☐ participating in recreational activities							
☐ appointments or meetings							
☐ bowel/bladder programs, range of motion exercises, routine wound care (per MD's orders and RN oversight)							
☐ general support to assure safety							
☐ activities in the workplace (does not duplicate services at the worksite)							
Training for assistant							
☐ as requested by the individual or caregiver that relates to services described in the ISP							

Comments:

_____ _____
Signature of Facilitator Date

I agree that the above plan of services is appropriate to the identified needs of this individual. This service plan has been approved by the individual and included in the CSP maintained in the Case Manager's record.

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

_____ _____
Signature Date

❑ Initiate Waiver services
❑ Service Modification
  € Add a service
  € Increasing level/hours of service
  € Decreasing level/hours of service
❑ Provider Modification (requires 2 ISARs)
❑ End a service

MR Waiver
Consumer-Directed Respite
Individual Service Authorization Request

CSB _____

CSB provider #

_____

Name: _____ Medicaid No. _____
Last, First MI

_____ _____ _____ Reassessment? Y__ N__
Services Facilitator (SF) Provider No. SF Start Date

SF agency, if applicable _____ CD Assistant _____

Will the individual be directing his or her own services? ☐ Yes ☐ No	If NO, name and relationship of responsible family caregiver:

SERVICE TO BE PROVIDED	HOURS NEEDED	OMR USE ONLY
CD Respite Start Date _____		

Reason for this request: _____

_____

Check the allowable activities included in the individual's ISP. Indicate the *total* number of hours per day of CD Respite, not to exceed 720 hours per calendar year (including agency-directed).

Assistance with	**Sun**	**Mon**	**Tue**	**Wed**	**Thur**	**Fri**	**Sat**
☐ activities of daily living							
☐ monitoring health status & physical condition							
☐ self-medication and/or other medical needs							
☐ meal preparation and eating							
☐ housekeeping activities							
☐ participating in recreational activities							
☐ appointments or meetings							
☐ bowel/bladder programs, range of motion exercises, routine wound care (per MD's orders and RN oversight)							
☐ general support to assure safety							
Training for assistant							
☐ as requested by the individual or caregiver that relates to services described in the ISP							

Comments:

List any current or previously authorized Respite providers and hours since January of this year:_____

_____

_____ _____
Signature of Facilitator Date

I agree that the above plan of services is appropriate to the identified needs of this individual. This service plan has been approved by the individual and included in the CSP maintained in the Case Manager's record.

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

_____ _____
Signature Date

❑ Initiate Waiver services
❑ Service Modification
  € Add a service
  € Increasing level/hours of service
  € Decreasing level/hours of service
❑ Provider Modification (requires 2 ISARs)
❑ End a service

MR Waiver Crisis Stabilization
Individual Service Authorization Request

CSB _____

CSB provider #

_____

Provider Name _____ Provider Number _____

Name: _____ Start: _____ End: _____
Last First MI Date Date

Medicaid Number: _____

CHECK SERVICE TO BE PROVIDED	HOURS NEEDED	OMR USE ONLY
☐ Z8999 Clinical/Behavioral Intervention [15 day limit; maximum 60 days in calendar yr]		
☐ Z8899 Crisis Supervision [allowable only if Z8999 is provided] ► **Provider** (if different): Name: Number:		

Days used this calendar year: _____

Reason for this request: _____

Documentation in the case record indicates the individual: (Check all that apply; must meet at least one)
- ☐ is experiencing marked reduction in psychiatric, adaptive or behavioral functioning
- ☐ is experiencing extreme increase in emotional distress
- ☐ needs continuous intervention to maintain stability
- ☐ is causing harm to self or others

The individual is at risk of: (Check all that apply; must meet at least one)
- ☐ psychiatric hospitalization
- ☐ emergency ICF/MR placement
- ☐ disruption of community status (living arrangement, day placement, school)
- ☐ causing harm to self or others

A face-to-face ☐ assessment ☐ reassessment was completed by a qualified qmrp:

_____ _____ _____
Name Agency Date

<u>An Individual Service Plan outlining the specific activities of professionals and staff:</u>

☐ **has been received by the case manager.**

☐ **will be received within 72 hours of the assessment/reassessment by the qmrp.**

Individual Name:
Last First MI

Check the following allowable activities included in the individual's plan.

☐ Psychiatric, neuropsychiatric, psychological assessment & other functional assessments & stabilization techniques
☐ Medication management & monitoring
☐ Behavior assessment & behavior support
☐ Intensive care coordination with other agencies/providers to assist in planning & delivery of services & supports to maintain community placement of individual
☐ Training of family members, other care givers & service providers in positive behavioral supports to maintain the individual in the community

☐ Temporary crisis supervision to ensure the safety of the individual and others

Comments: _____

Name of Provider Agency Representative/Clinical Intervention (print) Signature Date

Name of Provider Agency Representative/ Crisis Supervision (print) Signature Date

I agree that the above plan of services is appropriate to the identified needs of this individual. This service plan 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

- ❑ Initiate Waiver services
- ❑ Service Modification
  - € Add a service
  - € Increasing level/hours of service
  - € Decreasing level/hours of service
- ❑ Provider Modification (requires 2 ISARs)
- ❑ End a service

MR Waiver Day Support
Individual Service Authorization Request

CSB _____

CSB provider #

_____

Provider Name _____ Provider No. _____

Name: _____ (Last, First, MI) | ISP Start: _____ (Date) | ISP End: _____ (Date)

Medicaid Number: _____

CHECK SERVICE TO BE PROVIDED	WEEKLY / YEARLY UNITS			OMR USE ONLY
☐ Z8556 Day Support, Reg Int. Center Based ☐ Z8557 Day Support, High Int. Center Based ☐ Z8560 Day Support, Reg Int. Non Center Based ☐ Z8561 Day Support, High Int. Non Center Based	_____ Units / week	x 52 =	_____ Yearly total	

Reason for this request: _____

Check the allowable activities that are included in the individual's plan.

If High Intensity, check which criteria are met:

☐ Requires physical assistance to meet basic personal care needs

☐ Has extensive disability-related difficulties and requires additional, ongoing support to fully participate in programming and to accomplish individual service goals

☐ Requires extensive personal care and/or constant supports to reduce or eliminate behaviors which preclude full participation in programming. [A formal written behavioral program or behavioral objective is required to address behaviors such as self-injury or self-stimulation.]

Training in Functional Skills

☐ self, social, environmental awareness
☐ sensory stimulation, gross/fine motor
☐ communication
☐ personal care
☐ use of community resources, safety
☐ learning and problem solving
☐ adapting behavior to social and community settings

Assistance and Supervision

☐ with personal care and use of community resources
☐ to ensure the individual's health and safety
☐ travel between activity and training sites
☐ opportunities to use functional skills in community settings
☐ to ensure the individual's health and safety

Record the number of hours per day of the following: *(for biweekly/varied schedules, draw a line to indicate different weeks)*	**SUN**	**MON**	**TUES**	**WED**	**THU**	**FRI**	**SAT**
Total Hours of Program Time *(e.g., if individual is in program from 8 a.m. until noon, enter "4")*							
Travel with the individual to & from program: *[record if billing for this time; can be included up to 25% of the total time; to bill for a 3-unit day, a minimum of 7 hrs of other allowable activities is required; does not include training related travel in scheduled activities]*							

ATTACH ADDITIONAL PAGES IF FURTHER EXPLANATION IS NEEDED.

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

I agree that the above plan of services is appropriate to the identified needs of this individual. This service modification 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 _____

- ❑ Initiate Waiver services
- ❑ Service Modification
  - € Add a service
  - € Increasing level/hours of service
  - € Decreasing level/hours of service
- ❑ Provider Modification (requires 2 ISARs)
- ❑ End a service

MR Waiver Environmental Modification
Individual Service Authorization Request

CSB _____

CSB provider #

_____

Provider Name _____ Provider Number _____

Name: _____ Start: _____ End: _____

Last, First MI Date Date

Medicaid No. _____

The individual must have at least one other MR Waiver service to receive this service.

CHECK SERVICE TO BE PROVIDED	COST	OMR USE ONLY
☐ Z8599 Environmental Mod; Rehab Engineer		
☐ Z8600 Environmental Mod; Structural		
☐ Z8601 Environmental Mod; Supply Cost Only		
☐ Z8602 Environmental Mod; Transportation		

Maximum Expenses = $5,000 per CSP year Note previous expenses this CSP yr: _____

Reason for this request: _____

Check the following as needed by the individual:

☐ Physical adaptation of a house or place of residence necessary to assure an individual's health & safety

☐ Physical adaptation of a house or place of residence which enable an individual to live in a non-institutional setting and to function with greater independence

☐ Environmental Modification to a work site (which exceeds the requirements of ADA) needed by an individual who is receiving MR Waiver Supported Employment

☐ Modification to the individual's primary vehicle

☐ Rehabilitation Engineering (reason needed): _____

Describe the specific modifications, equipment, supplies and/or other services to be provided:

Comments: _____

I agree that the above plan of services is appropriate to the identified needs of this individual. This service plan 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

- ❑ Initiate Waiver services
- ❑ Service Modification
  - € Add a service
  - € Increasing level/hours of service
  - € Decreasing level/hours of service
- ❑ Provider Modification (requires 2 ISARs)
- ❑ End a service

MR Waiver Skilled Nursing Services
Individual Service Authorization Request

CSB _____

CSB provider #

_____

Provider Name _____ Provider Number _____

Name: _____ Start: _____ End: _____

Last, First MI Date Date

Medicaid Number: _____

CHECK ✔SERVICE TO BE PROVIDED	WEEKLY / YEARLY HOURS			OMR USE ONLY
☐ Z9401 Skilled Nursing – RN	_____ Hours / week	x 52 =	_____ Yearly total	
☐ Z9402 Skilled Nursing – LPN	_____ Hours / week	x 52 =	_____ Yearly total	

Reason for this request:

_____

_____

_____

Check the allowable activities included in the individual's plan.

(Must have documentation of medical necessity by a physician; short term skilled nursing needs should be covered under the Medicaid State Plan.)

- ☐ Monitoring individual's medical status
- ☐ Administering medication or other medical treatment
- ☐ Training family members, staff or other persons to monitor individual's medical status
- ☐ Training family members, staff or other persons to administer medications
- ☐ Training family members, staff or other persons to perform medically related procedures

Comments: _____

Name of Provider Agency Representative (print) Signature Date

I agree that the above plan of services is appropriate to the identified needs of this individual. This service plan 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

- ❑ Initiate Waiver services
- ❑ Service Modification
  - € Add a service
  - € Increasing level/hours of service
  - € Decreasing level/hours of service
- ❑ Provider Modification (requires 2 ISARs)
- ❑ End a service

MR Waiver
Personal Emergency Response System
Individual Service Authorization Request

CSB _____

CSB provider #

_____

Provider Name _____ Provider Number _____

Name: _____ Start: _____ End: _____

Last, First MI Date Date

Medicaid Number: _____

CHECK SERVICE TO BE PROVIDED	UNITS	OMR USE ONLY
☐ Y0071 Personal Emergency Response System Installation		
☐ Y0072 PERS & Medication Monitoring Installation		
☐ Y0073 PERS Monitoring		
☐ Y0074 PERS & Medication Monitoring		
☐ Y0075 PERS Nursing RN (to fill Med Monitoring Unit)		
☐ Y0076 PERS Nursing LPN (to fill Med Monitoring Unit)		

Reason for this request (To qualify, no one else competent in home or continuously available to call for help)

Check the following regarding the PERS:

☐ Individual lives alone and has no regular caregiver for extended periods of time.
☐ Individual is alone for significant parts of the day and has no regular caregiver for extended periods of time.
☐ Individual requires extensive routine supervision.
☐ Individual requires Medication Monitoring Unit; date of physician's order is _____.

Comments:

I agree that the above plan of services is appropriate to the identified needs of this individual. This service plan 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

- ❑ Initiate Waiver services
- ❑ Service Modification
  - € Add a service
  - € Increasing level/hours of service
  - € Decreasing level/hours of service
- ❑ Provider Modification (requires 2 ISARs)
- ❑ End a service

CSB _____

CSB provider #

_____

MR Waiver Agency-Directed Personal Assistance Individual Service Authorization Request

Provider Name _____ Provider Number _____

Name: _____ (Last, First MI) | Start: _____ (Date) | End: _____ (Date)

Medicaid Number: _____

SERVICE TO BE PROVIDED	WEEKLY / YEARLY HOURS	OMR USE ONLY
Personal Assistance – Z4036	_____ Hours / week x 52 = _____ Yearly total (1)	
	+	
Enter periodic support hours per week (if needed) →	_____ Hours / week	
	=	
Enter total of periodic support hours + regular hours per week →	_____ Hours / week x 52 = _____ Yearly total (2)	

Reason for the request: _____

Answer the questions and check the allowable activities included in the individual's plan. Indicate the *total* number of hours per day.

Does the individual need training and skills development?
☐ Yes ☐ No

If Yes, in what other service or program is the training and skills development received?

Assistance with	**Sun**	**Mon**	**Tue**	**Wed**	**Thur**	**Fri**	**Sat**
☐ activities of daily living ***(Must need to receive PA)***							
☐ monitoring health status & physical condition							
☐ medication and/or other medical needs							
☐ meal preparation and eating							
☐ housekeeping activities							
☐ participating in recreational activities							
☐ appointments or meetings							
General Support							
☐ to assure health and safety of the individual							

Comments:

Name of Provider Agency Representative (print) Signature Date

I agree that the above plan of services is appropriate to the identified needs of this individual. This service plan 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

❑ Initiate Waiver services
❑ Service Modification
- € Add a service
- € Increasing level/hours of service
- € Decreasing level/hours of service

❑ Provider Modification (requires 2 ISARs)
❑ End a service

MR Waiver Prevocational Services
Individual Service Authorization Request

CSB _____

CSB provider #

_____

Provider Name _____ Provider No. _____

Name: _____ ISP Start: _____ ISP End: _____
Last, First MI Date Date

Medicaid Number: _____

CHECK SERVICE TO BE PROVIDED	WEEKLY / YEARLY UNITS			OMR USE ONLY
☐ PREVOC Prevocational, Reg Int. Center Based ☐ PREVOC Prevocational, High Int. Center Based ☐ PREVOC Prevocational, Reg Int. Non Center Based ☐ PREVOC Prevocational, High Int. Non Center Based	_____ Units / week	x 52 =	_____ Yearly total	

Reason for this request: _____

If High Intensity, check which criteria are met:

☐ Requires physical assistance to meet basic personal care needs

☐ Has extensive disability-related difficulties and requires additional, ongoing support to fully participate in programming and to accomplish individual service goals

☐ Requires extensive personal care and/or constant supports to reduce or eliminate behaviors which preclude full participation in programming. [A formal written behavioral program or behavioral objective is required to address behaviors such as self-injury or self-stimulation.]

Check the allowable activities that are included in the individual's plan:

Training & support

☐ in skills aimed at preparation for paid employment offered in a variety of community settings

☐ in activities primarily directed at habilitative goals (e.g., attention span and motor skills)

☐ that is focused on completing assignments, solving problems or safety

Assistance & supervision

☐ with personal care

☐ to ensure the individual's health and safety

Travel

☐ with the individual to and from work sites, when other travel assistance unavailable

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**

Record the number of hours per day of the following: *(for biweekly/varied schedules, draw a line to indicate different weeks)*	**SUN**	**MON**	**TUES**	**WED**	**THU**	**FRI**	**SAT**
Total Hours of Program Time *(e.g., if individual is in program from 8 a.m. until noon, enter "4")*							
Travel with the individual to & from program: *[record if billing for this time; can be included up to 25% of the total time; to bill for a 3-unit day, a minimum of 7 hrs of other allowable activities is required; does not include training related travel in scheduled activities]*							

ATTACH ADDITIONAL PAGES IF FURTHER EXPLANATION IS NEEDED.

Name of Provider Agency Representative (print) Signature Date

I agree that the above plan of services is appropriate to the identified needs of this individual. This service modification 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

❑ Initiate Waiver services
❑ Service Modification
- € Add a service
- € Increasing level/hours of service
- € Decreasing level/hours of service

❑ Provider Modification (requires 2 ISARs)
❑ End a service

MR Waiver Residential Support
Individual Service Authorization Request

CSB _____

CSB provider #

_____

Provider Name _____ Provider Number _____

Name: _____ (Last, First MI) Start: _____ (Date) End: _____ (Date)

Medicaid Number: _____

CHECK SERVICE TO BE PROVIDED	WEEKLY / YEARLY HOURS	OMR USE ONLY
☐ Z8595 Supported Living / I n-Home ☐ Z8551 Congregate (please specify below) ☐Group Home ☐Group Home for Children ☐Adult Foster Care Home ☐Assisted Living Facility ☐Sponsored Placement ☐Other:	_____ Hours / week x 52 = _____ Yearly total (1)	
Enter periodic support hours per week (if needed) →	+ _____ Hours / week =	
Enter total of periodic support hours + regular hours per week →	_____ Hours / week x 52 = _____ Yearly total (2)	

Reason for this request:

_____

Check the allowable activities that are included in the individual's plan. Indicate the *total* number of hours of program time per day.

	Sun	Mon	Tues	Wed	Thur	Fri	Sat
Training in Functional Skills ☐ personal care and activities of daily living; ☐ use of community resources; ☐ adaptive behavior for home and community environments **Assistance and specialized supervision (excluding nighttime) with** ☐ personal care ☐ activities of daily living, use of community resources ☐ medication, med needs, monitoring health & physical condition ☐ travel to & from training sites and community resources							
Nighttime Specialized Supervision -- If applicable, indicate hours needed and provide explanation:							

What will staff do for Nighttime Specialized Supervision?

ATTACH ADDITIONAL PAGES IF FURTHER EXPLANATION IS NEEDED.

Name of Provider Agency Representative (print) Signature Date

I agree that the above plan of services is appropriate to the identified needs of this individual. This service plan 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

- ❑ Initiate Waiver services
- ❑ Service Modification
  - € Add a service
  - € Increasing level/hours of service
  - € Decreasing level/hours of service
- ❑ Provider Modification (requires 2 ISARs)
- ❑ End a service

MR Waiver Agency-Directed Respite
Individual Service Authorization Request

CSB _____

CSB provider #

_____

Provider Name _____ Provider Number _____

Name: _____ Start: _____ End: _____

Last, First MI Date Date

Medicaid Number: _____

SERVICE TO BE PROVIDED	HOURS NEEDED	OMR USE ONLY
Z9421 Respite ☐ In-Home ☐ Center-Based ☐ Out-of-Home ☐ Residential		

Reason for this request:

_____

_____

_____

Check the allowable activities that are included in the individual's plan.

(Not available to individuals living with paid caregivers; cannot be provided by Foster/Family Care providers to their own resident. Maximum 720 Respite hours per year, including CD Respite.)

Assistance with:

- ☐ activities of daily living;
- ☐ monitoring health status & physical condition;
- ☐ medication and/or other medical needs;
- ☐ meal preparation & eating;
- ☐ housekeeping activities;
- ☐ participating in recreational activities; and/or
- ☐ appointments/meetings

Support:

- ☐ to assure health & safety of the individual

Comments: _____

_____

_____

Name of Provider Agency Representative (print) Signature Date

I agree that the above plan of services is appropriate to the identified needs of this individual. This service plan 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

- ❑ Initiate Waiver services
- ❑ Service Modification
  - € Add a service
  - € Increasing level/hours of service
  - € Decreasing level/hours of service
- ❑ Provider Modification (requires 2 ISARs)
- ❑ End a service

MR Waiver Supported Employment Individual Service Authorization Request

CSB _____

CSB provider #

_____

Provider Name _____ Provider Number _____

Name: _____ Start: _____ End: _____

Last, First MI Date Date

Medicaid Number: _____

CHECK SERVICE TO BE PROVIDED	WEEKLY / YEARLY HOURS OR UNITS	OMR USE ONLY
☐ Z8597 Supported Emp, Individual Placement	_____ Hours / week x 52 = _____ Yearly total	
☐ Z8598 Supported Emp., Group	_____ Units / week x 52 = _____ Yearly total	

Reason for this request: _____

Check the allowable activities that are included in the individual's plan.

- ☐ Individualized assessment & development of employment related goals
- ☐ Individualized job development
- ☐ On-the-job training in work & work-related skills required to perform the job
- ☐ Ongoing evaluation, supervision and monitoring of job performance beyond supervisor's responsibilities
- ☐ Ongoing support services necessary to assure job retention
- ☐ Training in related skills essential to obtaining & retaining employment
- ☐ Travel with the individual to and from work sites, when other travel assistance unavailable
- ☐ Other:

There is documentation in the record that Supported Employment Services cannot be obtained from the school system (for those less than 22 years) nor from Department of Rehabilitative Services? ☐ **Yes** ☐ **No**

Record the number of hours per day of the following: *(for biweekly/varied schedules, draw a line to indicate different weeks)*	**SUN**	**MON**	**TUES**	**WED**	**THU**	**FRI**	**SAT**
Total Hours of Program Time *(e.g., if individual is in program from 8 a.m. until noon, enter "4")*							
Travel with the individual to & from program: *[record if billing for this time; can be included up to 25% of the total time; to bill for a 3-unit day, a minimum of 7 hrs of other allowable activities is required; does not include training related travel in scheduled activities]*							

Comments: _____

Name of Provider Agency Representative (print) Signature Date

I agree that the above plan of services is appropriate to the identified needs of this individual. This service plan 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

❑ Initiate Waiver services
❑ Service Modification
  € Add a service
  € Increasing level/hours of service
  € Decreasing level/hours of service
❑ Provider Modification (requires 2 ISARs)
❑ End a service

MR Waiver Therapeutic Consultation Individual Service Authorization Request

CSB _____

CSB provider #

_____

Provider Name _____ Provider Number _____

Name: _____ Start: _____ End: _____
Last, First MI Date Date

Medicaid Number: _____

Only Behavioral Consultation may be provided in the absence of other MR Waiver services.

CHECK SERVICE TO BE PROVIDED	HOURS NEEDED	OMR USE ONLY
Z8565 Therapeutic Consultation ☐ Behavioral ☐ Psychological ☐ Speech ☐ Occupational ☐ Physical ☐ Recreational ☐ Rehabilitation Engineering		

Reason for this request:

Check the allowable activities that are included in the individual's plan. Indicate the approximate total number of hours.

(May not be direct therapy, evaluations, or services available through the Medicaid State Plan.)	**Hours needed in each area**
Assessment/evaluation: ☐ interviewing to identify issues to be addressed/desired outcomes	
Training, consultation & technical assistance to program staff/family: ☐ training in better supporting the individual through enhanced observations of environment/routines/interactions ☐ reviewing documentation & evaluating staff/family activities ☐ 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: ☐ designing & developing a written Support Plan ☐ 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 of services is appropriate to the identified needs of this individual. This service plan 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