

**MR Waiver Transition Services (Funding)
Individual Service Authorization Request**

Initiate Waiver services
 Service Modification
 Add a service

CSB _____

CSB provider # _____

| | | | | |
|--|-------|------------|---|--------------|
| Name: | | | Start: | End: |
| Last, | First | MI | Date | Date |
| Medicaid No. _____ | | | This service may be authorized for no longer than 9 mos. from the start date. | |
| CHECK SERVICE TO BE PROVIDED | | | COST | OMR USE ONLY |
| <input type="checkbox"/> T2038 Transition Services | | \$5,000.00 | | |

This service may only be provided to an individual transitioning to a living arrangement in a private residence in which he/she is directly responsible for his/her own living expenses. One transition per person per lifetime is permitted.

Reason for this request: _____

Check the following as needed by the individual:

Security deposits
 Moving expenses
 Set up fees/deposits for utilities (e.g., electricity, telephone, heating, water)
 Essential furnishings (e.g., bed, chairs, dining table, eating utensils, bed and bath linens, food preparation items, window coverings, washer, dryer, microwave, refrigerator, stove)
 Health and safety assurances such as pest eradication, allergen control or one-time cleaning
 Fees to obtain a birth certificate or driver's license
 Activities to assess needs, arrange for or obtain needed resources

 Other (please describe) _____

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