❑ Initiate Waiver services
❑ Service Modification
  □ Add a service
  □ Increasing hours of service
  □ Decreasing hours of service
❑ Change in SF (requires 2 ISARs)
❑ End CD service

MR Waiver
Consumer-Directed Personal Assistance
Individual Service Authorization Request

CSB _____

CSB provider #

_____

Last First MI Name:	Medicaid No:
Address: Street/Apt. City, State Zip Code	
Phone No. Social Security No.	Patient Pay Amount: $
Is this service designated to collect patient pay? ☐Yes ☐No ☐N/A SF agency, if applicable _____	
Services Facilitator: Provider No:	Reassessment? ☐Yes ☐No

Will the individual be directing his or her own services? ☐Yes ☐No

If NO, name and relationship of responsible family member/caregiver:_____

SERVICE REQUESTED	WEEKLY/YEARLY HOURS			OMR USE ONLY
Fill in applicable dates: **CD PA** services start date may not precede: SF Start Date:_____ SF End Date:_____ S5126--CD PA Start Date: _____ S5126--CD PA End Date: _____ Total # of persons with disabilities in the residence_____	_____ Hours / week	x 52 =	_____ Yearly total (1)	
Enter periodic support hours → per week if needed **(Do not include in daily hours in weekly schedule below)**	+ _____ 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 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 be included to receive this service)***							
☐ 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