- ❑ Initiate Waiver services
- ❑ Service Modification
  - ☐ Add a service
  - ☐ Increasing hours of service
  - ☐ Decreasing 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
☐ H2011 Crisis Stabilization (Clinical/Behavioral Intervention) [15 day limit; maximum 60 days in calendar yr]		
☐ H0040 Crisis Supervision [allowable only if H2011 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 ISP:

☐ 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

I

☐ 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