- ❑ Initiate Waiver services
- ❑ Service Modification
  - □ Add a service
  - □ Increasing hours of service
  - □ Decreasing hours of service
  - □ Procedure code modification (requires 2 ISAR's)
- ❑ Provider Modification (requires 2 ISARs)
- ❑ End a service

MR Waiver Supported Employment 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 OR UNITS	OMR USE ONLY
☐ H2023 Supported Emp, Individual Placement	_____ Hours / week x 52 = _____ Yearly total	
☐ H2024 Supported Emp., Group	_____ Units / week x 52 = _____ Yearly total	

Reason for this request: _____

Check the allowable activities that are included in the ISP:

- ☐ 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