- ❑ 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: _____ ISP Start: _____ ISP End: _____

Last, First MI Date 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