- ❑ Initiate Waiver services
- ❑ Service Modification
  - □ Add a service
  - □ Increasing hours of service
  - □ Decreasing hours of service
- ❑ Provider Modification (requires 2 ISARs)
- ❑ End a service

CSB _____

CSB provider #

_____

MR Waiver Agency-Directed Personal Assistance Individual Service Authorization Request

Provider Name _____ Provider Number _____

Name: _____ Start: _____ End: _____

Last, First MI Date Date

Medicaid Number: _____

SERVICE TO BE PROVIDED	WEEKLY / YEARLY HOURS	OMR USE ONLY
Personal Assistance – T1019 Total # of persons with disabilities in same residence:_____	_____ Hours / week x 52 = _____ Yearly total (1)	
Enter periodic support hours per week if needed –**Do not include in daily hours below.** →	+ _____ Hours / week	
Enter total of periodic support hours + regular hours per week →	= _____ Hours / week x 52 = _____ Yearly total (2)	

Reason for the request: _____

Answer the questions and check the allowable activities included in the ISP. Indicate the *total* number of hours per day for each section below:

Does the individual need training and skills development?
☐ Yes ☐ No

If Yes, in what other service or program is the training and skills development received?

Assistance with	**Sun**	**Mon**	**Tue**	**Wed**	**Thur**	**Fri**	**Sat**
☐ activities of daily living ***(Must be included to receive service)*** ☐ monitoring health status & physical condition ☐ medication and/or other medical needs ☐ meal preparation and eating ☐ housekeeping activities ☐ participating in recreational activities ☐ appointments or meetings							
General Support ☐ to assure health and safety of the individual							
TOTAL DAILY HOURS (Assistance + General Support)							

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