❑ 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/ID Waiver Agency-Directed Respite Individual Service Authorization Request

CSB _____

CSB provider #

_____

Provider Name _____ Provider E-mail address _____ Provider Number _____

Name: _____ Start: _____ End: _____
Last, First MI Date Date

Medicaid Number: _____

SERVICE TO BE PROVIDED	YEARLY HOURS NEEDED	ODS USE ONLY
T1005 Respite ☐ In-Home ☐ Center-Based ☐ Out-of-Home ☐ Residential		

Total AD and/or CD Respite Hours previously used this fiscal year**:** _____

Reason for this request: _____

Check the allowable activities that are included in the PFS:

Only available to individuals who have an unpaid primary caregiver living in the home; cannot be provided by Foster/Family Care providers to their own resident. Maximum is 480 hrs/fiscal year, including CD Respite.

Support with:

☐ activities of daily living
☐ monitoring health status & physical condition
☐ medication and/or other medical needs
☐ meal preparation & eating
☐ housekeeping activities
☐ participating in social/recreational/community activities
☐ appointments or meetings
☐ bowel/bladder programs, range of motion exercises, routine wound care (per MD's orders and RN oversight)
☐ assuring the safety of the individual

Comments: _____

Name of Provider Agency Representative (print) Signature Date

I agree that the above plan for supports is appropriate to the identified needs of this individual. This PFS has been approved by the individual and included in the ISP maintained in the Support Coordinator's/Case Manager's record.

CSB Rep/Supp. Coord./Case Manager (print) Signature Phone No. Fax No. Date