❑ Initiate CMH Program services
❑ Service Modification
  □ Add a service
  □ Increasing level/hours of service
  □ Decreasing level/hours of service
❑ Change in Provider (requires 2 ISARs)
❑ End a service

Case Management/Transition Coordination agency

_____

Provider #

_____

CMH Program
Agency-Directed Companion Services
Individual Service Authorization Request

Provider Name _____ Provider Number _____

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

Medicaid Number: _____

SERVICE TO BE PROVIDED	WEEKLY / YEARLY HOURS	DMAS USE ONLY
Companion – S5135	_____ Hours / week x 52 = _____ Yearly total (1)	

Reason for the request: _____

Answer the questions and check the allowable activities included in the client's plan. Indicate the *total* number of hours per day. Companion Services is limited to 8 hours per day.

Is there a therapeutic goal in the ISP?
☐ Yes ☐ No

Assistance or support with	**SUN**	**MON**	**TUE**	**WED**	**THUR**	**FRI**	**SAT**
☐ skill development							
☐ understanding family interaction							
☐ socialization, community access & recreational activities							
☐ behavioral interventions for support and safety							
☐ tasks such as meal preparation, laundry, shopping							
☐ supervision of housekeeping tasks							
☐ self-administration of medication							

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 client. This service plan has been approved by the client and family/caregiver, as appropriate, and included in the CSP maintained in the transition coordination/case management record.

Transition Coordinator/Case Manager (print) Signature Phone No. Fax No. Date