❑ 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/ID Waiver Agency-Directed Personal Assistance Individual Service Authorization Request

Provider Name | Provider E-mail address | Provider Number

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

Medicaid Number: _____

SERVICE TO BE PROVIDED	WEEKLY / MONTHLY HOURS			ODS USE ONLY
Personal Assistance – T1019 Total # of persons with disabilities in same residence:_____	_____ Hours / week	x 4.6 =	_____ Monthly total (A)	
Enter periodic support hours per month if needed – **Do not include in daily hours below.** →	_____ Hours / month	+ (A) =	_____ Monthly total (B)	

Reason for the request: _____

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?

Answer the questions and check the allowable activities below.

Indicate hours per/day.

Support 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 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							
☐ activities in the workplace or post-secondary school (does not duplicate ADA or SE services)							

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 Mgr. (print) | Signature | Phone No. | Fax No. | Date