□ Initiate Waiver service □ Service Modification (add a service) □ Provider Modification (requires 2 ISARs) □ End a service MR Waiver 60 Individual Service	•		uest	CSB CSB	provide	· #		
Provider Name		1 -				ler Numb	er	
Name: Last, First	MI	Start:	Date		End:	Da	te	
Medicaid Number:			Date			Da		
CHECK SERVICE TO BE PROVIDED ONLY		WEEKLY /	YEARLY	/ HOURS /	/UNITS		OMR	USE
Z8595 Supported Living / In-Home	Weekly Ho	urs x	52 =	Yearly H	lours			
☐ Z8551 Congregate (please specify below) ☐ Group Home ☐ Group Home for Children ☐ Adult Foster Care Home ☐ Assisted Living Facility ☐ Sponsored Placement ☐ Other:	Weekly Ho	urs x	52 =	Yearly H	lours			
Z4036 Personal Assistance	Weekly Ho	urs x	52 =	Yearly H	lours			
Enter periodic support hours <i>per week</i> (if needed)—RS and PA only.	Weekly Ho	urs						
Enter total of periodic support hours + regular hours per week	Weekly Ho	urs x	52 =	Yearly H	lours			
Z8556 DS or □PREVOC Reg. Int. Center-Based □Z8557 DS or □PREVOC High Int. Center-Based □Z8560 DS or □PREVOC Reg. Int. Non-Center-Based □Z8561 DS or □PREVOC High Int. Non-Center-Based	Weekly Ur	nits x	52 =	Yearly U	Jnits			
Z8597 Supported Employment, Individual Placement	Weekly Ho	urs x	52 =	Yearly H	lours			
Z8598 Supported Employment, Enclave/Work Crew	Weekly Ur	nits x	52 =	Yearly U	Jnits			
While providing the agreed-upon supports and services, a 60-day assessment must be used to 1) evaluate the individual's needs and interests in the service environment and community settings and 2) develop an annual service plan. Why is this assessment period needed for this individual?								
Check the allowable activities that are included in the plan. Indicate	the total num	ber of hou	rs per d	ay:				
Assessment of and assistance with: participation in a variety of settings and activities all life skill areas related to the service, including identification personal preferences health and safety issues	of	Sun	Mon	Tues	Wed	Thur	Fri	Sat
needs for nighttime specialized supervision (residential only)								
Travel with the individual to and from DS/SE/PREVOC p (record if billing for this time; can be included up to 25% of the tota for a 3-unit day, a minimum of 7 hrs of other allowable activities is does not include training related travel in scheduled activities)	al time; to bill							
ATTACH ADDITIONAL PAGES IF FURTHER EXPLANATION IS We, the undersigned, assure that the assessment ISP will be followed by the individual) by the end of the 60-day period.		and implem	nentation	of an annı	ual ISP (a	pproved k	by the	

Name of Provider Agency Representative (print)

Signature

Date

In addition to the assurance above, I agree that the assessment 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

Initiate Waiver services Service Modification € Add a service € Increasing level/hours of service	Individual Se	er Assistive Tech rvice Authorizati		CSB		
€ Decreasing level/hours of service Provider Modification (requires 2 ISAF					orovider #	
End a service						
Provider Name					Provider Number	
Name:			Start:		End:	
Last,	First	MI	Date		Date	
Medicaid Number:			The individual r Waiver service		e at least one other MR re this service.	
CHECK SERVICE TO BE PRO	VIDED	COST			OMR USE ONLY	
☐ Z8603 Assistive Techno	ology; Rehab Engineer					
☐ Z8604 Assistive Techno	ology; Off Shelf Item					
Z8605 Assistive Techno	ology; Supply Cost					
Maximum Expenses	= \$5,000 per CSP year	Note previous exper	nses this CSP yr:			
Reason for this request (attach documentation o	of recommendation	by a qualified p	rofessio	onal)	
Have any of the following be Explain:	en requested and denied (under Medicaid SPO [Durable Medical E	quipmer	nt? Yes No	
☐ Durable/non-durable med ☐ Adaptive devices, appliar	pment and ancillary equipr dical equipment and suppli nces, and/or controls which which enable an individual	es n enable an individual	to be more indepe		activities of daily living	

Comments:

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

Describe the specific modifications, equipment, supplies and/or other services to be provided:

□ Initiate Waiver services
 □ Service Modification
 ∈ Add a service
 ∈ Increasing level/hours of service
 € Decreasing level/hours of service

MR Waiver Consumer-Directed Companion Services Individual Service Authorization Request

CSB		 	
CSB	provider#		

ame:			Me	dicaid No).				
Last,	First		MI						
Service Facilitator (SF)	Provid	der No.		SF Start I	Date	Reassessment? Y N			
SF agency, if applicable	CD Companion								
Vill the individual be directing h ☐ Yes ☐ No	is or her own services?	If NO, caregiv		d relatior	nship of re	esponsibl	e family		
ERVICE TO BE PROVIDED	WEE	KLY / YEAR	LY HOURS	6		OMR	USE ON	LY	
CD Companion Services									
Start Date	Hours / week	x 52	= \frac{1}{2}	early tot	al (1)				
heck the allowable activities incluervices. Companion services can					per day of	expected	CD Com	npanion	
Check the allowable activities incluervices. Companion services can assistance or support with allowable tasks such as meal preparat light housekeeping tasks self-administration of medical community access and recre	not exceed a total of eight hour ion, laundry and shopping ation	s per day p	er individu	ıal.					
Check the allowable activities incluervices. Companion services can assistance or support with tasks such as meal preparat light housekeeping tasks self-administration of medica	not exceed a total of eight hour ion, laundry and shopping ation	s per day p	er individu	ıal.					
heck the allowable activities incluervices. Companion services can assistance or support with tasks such as meal preparat light housekeeping tasks self-administration of medical community access and recreshealth and safety	not exceed a total of eight hour ion, laundry and shopping ation eational activities	s per day p Sun	er individu Mon	ıal.					
heck the allowable activities incluervices. Companion services can sistance or support with asks such as meal preparat light housekeeping tasks self-administration of medica community access and recreshealth and safety omments:	not exceed a total of eight hour ion, laundry and shopping ation eational activities	s per day p Sun	er individu Mon	ıal.					
heck the allowable activities incluervices. Companion services can sistance or support with tasks such as meal preparat light housekeeping tasks self-administration of medical community access and recreated health and safety omments:	not exceed a total of eight hour ion, laundry and shopping ation eational activities ed Companion services pro	s per day p Sun	er individu Mon	ual. Tue	Wed	Thur	Fri	Sat	

☐ Initiate Waiver services ☐ Service Modification € Add a service

MR Waiver

CSB	
CSB provider #	

E Doorgooing lovel/bourg of convice	Consumer-Directed					provider #	+	
Name:			Med	dicaid No).			
Last,	First		MI					
			_			Reasse	ssment?	Y N_
Services Facilitator (SF)	Provide	er No.	S	SF Start I	Date			
SF agency, if applicable		ssistant						
Will the individual be directing his or I ☐ Yes ☐ No	ner own services?	If NO, caregiv	name and /er:	d relation	ship of re	esponsible	e family	
SERVICE TO BE PROVIDED	WEEK	LY / YEAR	LY HOURS			OMR	USE ONL	_Y
CD Personal Assistance – Y0078 Start Date	Hours / week	x 52	= <u>Y</u>	early tota	al (1)			
Reason for this request:								
Check the allowable activities included in Assistance with activities of daily living (Must need monitoring health status & physical self-medication and/or other medication and eating housekeeping activities participating in recreational activitical appointments or meetings bowel/bladder programs, range routine wound care (per MD's orders and general support to assure safety activities in the workplace (does at the worksite) Training for assistant as requested by the individual of to services described in the ISP Comments:	d to receive PA) al condition cal needs es of motion exercises, and RN oversight) not duplicate services	ate the to	Mon Mon	of hours Tue	per day of Wed	CD PA.	Fri	Sat
Signature of Facilitator						Date		
I agree that the above plan of services is appropriately included in the CSP maintained in the Case M		of this ind	ividual. This	service pl	an has beer	n approved	by the ind	ividual and
CSB Rep/ Case Manager (print)			Phone	No.		Fax N	0.	
Signature			Date					

 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 V Consumer-Di Individual Service A				CS	SB		
Name:			Med					
Last,	First		MI					
						Reasse	essment	? Y N
Services Facilitator (SF)	Provide	er No.	5	SF Start [Date			
SF agency, if applicable		CD A	ssistant					
Will the individual be directing I ☐ Yes ☐ No	nis or her own services?	If NO, caregi		d relation	ship of r	esponsibl	e family	
SERVICE TO BE PROVIDED		ЦΩ	URS NEED!	ED		OM	R USE ON	JI V
CD Respite		110	OKS NEED	LD		Olvii	N USL OF	VL I
Start Date	_							
Check the allowable activities inclu 720 hours per calendar year (inclu Assistance with activities of daily living monitoring health status & p self-medication and/or other meal preparation and eating housekeeping activities participating in recreational appointments or meetings bowel/bladder programs, routine wound care (per MD's or	chysical condition redical needs activities range of motion exercises, reders and RN oversight)					f CD Resp	Fri	Sat
to services described in the ISF	dual or caregiver that relates							
Comments:								
List any current or previously a	uthorized Respite providers a	nd hours	since Ja	nuary of	this year	n		
Signature of Facilitator						Date		
I agree that the above plan of services included in the CSP maintained in the		of this ind	ividual. This	service pla	an has bee	en approved	by the inc	dividual and

Date

Fax No.

Signature

CSB Rep/ Case Manager (print)

☐ Initiate Waiver services☐ Service Modification € Add a service € Increasing level/hours of service € Decreasing level/hours of service ☐ Provider Modification (requires 2 ISA ☐ End a service
Provider Name
Name:
Loct

CSB	
CSB	provider #

 € Increasing level/hours of service € Decreasing level/hours of service □ Provider Modification (requires 2 ISARs) □ End a service 		R Waiver Crisi ual Service Au				CSB provider #
Provider Name		_				Provider Number
Name:				Start:		End:
Last	First		MI	O to. t.	Date	Date
Medicaid Number:						
CHECK SERVICE TO BE PROVIDED		HOURS NEEDED	OMR	USE ONLY		
Z8999 Clinical/Behavioral Interve						
Z8899 Crisis Supervision [allowable only if Z8999 is provided]						
► Provider (if different):						
Name:						
Number:						
Days used this calendar year:	_					
Reason for this request:						
	_					
Documentation in the case recording is experiencing marked recording is experiencing extreme in needs continuous interver is causing harm to self or the individual is at risk of: (Chectopsychiatric hospitalization emergency ICF/MR placedisruption of community sold causing harm to self or other cases assessment recording reactions.)	eduction in ncrease in ntion to ma others ck all that ment tatus (livin	psychiatric, adap emotional distress aintain stability apply; must meet a	at least one	ent, school)		eet at least one)
		•				
Name			Agency			Date
An Individual Service Plan outlining	the specif	fic activities of pro	fessionals a	and staff:		

 $\hfill \square$ has been received by the case manager.

 $\hfill \square$ will be received within 72 hours of the assessment/reassessment by the qmrp.

Page 6 of 18 DMAS-430 Revised 1/2002

Individual Name:			
Last	First	MI	
Check the following allowable activities included	in the individual's plan.		
Psychiatric, neuropsychiatric, psychological asses Medication management & monitoring Behavior assessment & behavior support Intensive care coordination with other agencies/primaintain community placement of individual Training of family members, other care givers & sindividual in the community	oviders to assist in plannin	g & delivery of services	s & supports to
	I		
☐ Temporary crisis supervision to ensure the safety	of the individual and others	s	
Comments:			3
Name of Provider Agency Representative/Clinical Intervention (print)	Signature		Date
Name of Provider Agency Representative/ Crisis Supervision (print)	Signature		Date
I agree that the above plan of services is appropriate to the identifincluded in the CSP maintained in the Case Manager's record.	ied needs of this individual. This s	service plan has been approv	red by the individual and
CSB Rep/ Case Manager (print) Signature	Phone No.	Fax No.	Date

DMAS-430 Revised 1/2002 Page 7 of 18

 □ 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 Wa Individual Serv					equest	CSB CSB	provider #		
Dunidan Norsa								Daniel	lan Nia	
Provider Name								Provid	ier ivo.	
Name:					ISP :	Start:		ISP E	nd:	
Last,	First		M	I			Date		Date	
Medicaid Number:										
0.115014.05501405.70.05										.,
CHECK SERVICE TO BE PROVIDED Z8556 Day Support, Reg Int. Cer	nter Based		WEEKL	.Y / YE	ARLY	I		OM	R USE ONI	_Y
Z8557 Day Support, High Int. Ce										
Z8560 Day Support, Reg Int. No		Llaita /		FO		V	. 4 - 4 - 1			
Z8561 Day Support, High Int. No	n Center Based	Units /	week	x 52		Yearly	totai			
Reason for this request:										
Check the allowable activities that are in	cluded in the individual'	's plan.								
If High Intensity, check which crit Requires physical assistance to the Has extensive disability-related congoing support to fully particle accomplish individual service goals	meet basic personal of difficulties and require	es additi	ional, d to	suppo preclu writter	orts to the decision of the de	to reduc ull partici navioral p address	e or el ipation ir orogram	iminate prograr or behav	e and/or of behaviors nming. [A vioral objections self-injury	which formal ective is
Training in Functional Skills ☐ self, social, environmental aware	noss					l care				
sensory stimulation, gross/fine m			use of community resources, safety							
communication			 ☐ learning and problem solving ☐ adapting behavior to social and community settings 							
Assistance and Supervision					apmi	y Doriavio		. 4114 0011	inianity of	yttii igo
 □ with personal care and use of co □ to ensure the individual's health a □ travel between activity and training 	and safety						ctional ski s health a		munity se	ettings
Record the number of hours per of	day of the following.	:	SUN	M	ON	TUES	WED	THU	FRI	SAT
(for biweekly/varied schedules, draw a line	to indicate different wee	eks)	3014	IVI	ON	1023	WLD	1110	TKI	JAI
Total Hours of Program Time										
(e.g., if individual is in program from 8 a.m. Travel with the individual to & fro [record if billing for this time; can be include bill for a 3-unit day, a minimum of 7 hrs required; does not include training related tr	m program: ed up to 25% of the total of other allowable acti	ivities is								
ATTACH ADDITIONAL PAGES IF FU	JRTHER EXPLANATI	ION IS N	IEEDED							
Name of Devider Assessed	(m. wi 4)	0:							Det	
Name of Provider Agency Representative	,	Signatu		lis de se l	Th:-		dification t	aa baar a :-	Date	-
I agree that the above plan of services is a individual and included in the CSP maintain				ııvıdüäl.	. IIIIS S	service mo	unication na	аз вееп ар	provea by ti	i C

Fax No.

Date

CSB Rep/Case Manager (print)

Signature

MR Waiver Environmental Modification ☐ Initiate Waiver services **Individual Service Authorization Request** ■ Service Modification CSB ___ € Add a service € Increasing level/hours of service CSB provider # € Decreasing level/hours of service ☐ Provider Modification (requires 2 ISARs) ■ End a service Provider Name Provider Number Name: Start: End: Date The individual must have at least one other MR Medicaid No. Waiver service to receive this service. CHECK SERVICE TO BE PROVIDED COST OMR USE ONLY Z8599 Environmental Mod; Rehab Engineer ☐ Z8600 Environmental Mod; Structural Z8601 Environmental Mod; Supply Cost Only ☐ Z8602 Environmental Mod; Transportation Maximum Expenses = \$5,000 per CSP year Note previous expenses this CSP yr: Reason for this request: Check the following as needed by the individual: Physical adaptation of a house or place of residence necessary to assure an individual's health & safety ☐ Physical adaptation of a house or place of residence which enable an individual to live in a non-institutional setting and to function with greater independence ☐ Environmental Modification to a work site (which exceeds the requirements of ADA) needed by an individual who is receiving MR Waiver Supported Employment ☐ Modification to the individual's primary vehicle Rehabilitation Engineering (reason needed): Describe the specific modifications, equipment, supplies and/or other services to be provided: Comments:

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

☐ Initiate Waiver services					
□ Service Modification				CSB	
I	/IR Waiver Skille	_	ervices	CSB provider #	
	ividual Service	Authorization	Request		
☐ Provider Modification (requires 2 ISARs)☐ End a service					
Lift a service					
Provider Name				Provider Number	r
Name:		5	Start:	End:	
Last,	First	MI	Date	Da	te
Medicaid Number:					
CHECK ✓SERVICE TO BE PROVIDED	WEEKLY /	YEARLY HOURS		OMR USE ONLY	
70404 Chilled Nursing DN					
Z9401 Skilled Nursing – RN	Hours / week	x 52 =	Yearly total		
				1	
Z9402 Skilled Nursing – LPN	Hours / week	x 52 =	Yearly total		
Reason for this request:	Tiodio / Wook	X 02 -	Today total	1	
reacee. une requeen					
	_				
Check the allowable activities included in the	individual's plan.				
(Must have documentation of medical necessit Plan.)	y by a physician; sho	rt term skilled nursi	ng needs should be	e covered under the Medica	id State
Monitoring individual's medical status	ical tractment				
☐ Administering medication or other medi☐ Training family members, staff or other		individual's medic	cal status		
☐ Training family members, staff or other	-		odi otatao		
☐ Training family members, staff or other			procedures		
Commonts					
Comments:					
Name of Provider Agency Representative (print)	Sign	ature		Date	
I agree that the above plan of services is appropria	ate to the identified need		This service plan has	been approved by the individ	lual and
included in the CSP maintained in the Case Mana	ует 8 тесога.				

Signature

Date

Fax No.

CSB Rep/ Case Manager (print)

☐ Initiate Waiver services ☐ Service Modification

MR Waiver Personal Emergency Response System

CSB			
CSB	provider#		

 € Add a service € Increasing level/hours of service € Decreasing level/hours of service □ Provider Modification (requires 2 ISARs) □ End a service 	Individual Service Aut	thorization	Request	CSB provider #
Provider Name		Lo		Provider Number
Name:			art:	End:
Last, Medicaid Number:	First	MI	Date	Date
CHECK SERVICE TO BE PROVI	DED	UN	IITS	OMR USE ONLY
☐ Y0071 Personal Emergency				
☐ Y0072 PERS & Medication N	Monitoring Installation			
☐ Y0073 PERS Monitoring				
☐ Y0074 PERS & Medication N	Monitoring			
☐ Y0075 PERS Nursing RN (to	fill Med Monitoring Unit)			
☐ Y0076 PERS Nursing LPN (t	o fill Med Monitoring Unit)			
Reason for this request (To	qualify, no one else competen	t in home or o	continuously a	available to call for help)
☐ Individual is alone for signific ☐ Individual requires extensive	s no regular caregiver for extender ant parts of the day and has no re	gular caregive	r for extended p	eriods of time.
Comments:				
I agree that the above plan of services included in the CSP maintained in the	s is appropriate to the identified needs of Case Manager's record.	this individual. Th	nis service plan has	s been approved by the individual and
CSB Rep/Case Manager (print)	Signature	Phone No.	Fax	No. Date

 □ 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 Ag Personal <i>i</i> ividual Service A	Assista	nce		CSE CSE	3	ŧ	
Provider Name						Provid	der Num	ber
Name:			Star	·+·		End:		
	First		MI		Date			Date
Medicaid Number:								
SERVICE TO BE PROVIDED	WEEKI	Y / YEARL	Y HOURS			OMR	USE ONI	_Y
Personal Assistance – Z4036	Hours / week	x 52	= <u>Y</u> 6	early tota	l (1)			
Enter periodic support hours per week (if needed)	Hours / week							
Enter total of periodic support hours + regular hours per week	Hours / week	x 52	= <u>Y</u> e	early tota	l (2)			
Reason for the request:								
Answer the questions and check the allowab		If Yes,	in what o		vice or p			er day. ining and
Yes No Assistance with		Sun	Mon	Tue	Wed	Thur	Fri	Sat
activities of daily living (Must need to monitoring health status & physical condition and/or other medical need meal preparation and eating housekeeping activities participating in recreational activities appointments or meetings General Support	ondition	Suii	WOII	Tue	wed	Titul		Sat
to assure health and safety of the inc	dividual							
Comments:	aividuai							
Name of Provider Agency Representative (print) I agree that the above plan of services is appropria included in the CSP maintained in the Case Mana			ridual. This	service pla	n has beei	n approved	Date by the ind	ividual and

Signature

Date

Fax No.

CSB Rep/ Case Manager (print)

☐ Initiate Waiver services □ Service Modification

CSB				
CSB	provi	der#		

€ Add a service	MR Waiver Prevo				CSB			
€ Increasing level/hours of service € Decreasing level/hours of service	Individual Service A	uthoriza	ation Re	equest	CSB	provider #		
☐ Provider Modification (requires 2 ISARs)								
☐ End a service								
Dravidar Nama						Dravid	or No	
Provider Name						Provid		
Name:	First	MI	ISP	Start:	Data	ISP Er		
Last,	First	MI			Date		Date	9
Medicaid Number:								
CHECK SERVICE TO BE PROVIDED		WEEKLY	/YEARLY	UNITS		ОМ	R USE ON	LY
PREVOC Prevocational, Reg Int								
PREVOC Prevocational, High In								
PREVOC Prevocational, Reg Int PREVOC Prevocational, High In		ts / week	- x 52	- Yes	arly total	•		
Reason for this request:	ii. Non Center based Om	to / Wook	X 02	_ 100	arry total			
Neason for this request.								
If High Intensity, check which crit	toria aro mot:							
Requires physical assistance to				es extens				
Has extensive disability-related		ional Si		to reduc				
ongoing support to fully partic		d to b		ull partici navioral p				
accomplish individual service goals				address				
			timulation				,	,
Check the allowable activities that are in	ncluded in the individual's plan:							
Training & support			,					
in skills aimed at preparation for in activities primarily directed at					gs			
that is focused on completing as				SKIIIS)				
Assistance & supervision	olgimento, colving problemo	or ouroty						
with personal care								
to ensure the individual's health	and safety							
Travel								
with the individual to and from w					ned from	. 4b.a.a.b		lana (fan
There is documentation in the r those less than 22 years) nor from					es 🗌 N		iooi sysi	em (ioi
Record the number of hours per		litative c	1003					
(for biweekly/varied schedules, draw a line	•	SUN	MON	TUES	WED	THU	FRI	SAT
Total Hours of Program Time								
(e.g., if individual is in program from 8 a.m.	a. until noon, enter "4")							
Travel with the individual to & fro								
[record if billing for this time; can be includ	led up to 25% of the total time; to							
bill for a 3-unit day, a minimum of 7 hr required; does not include training related to								
ATTACH ADDITIONAL PAGES IF F		JEEDED						ı
ATTAON ADDITIONAL TAGES II T	OKTILK EXI EXIVATION IOT	ILLDLD.						
Name of Provider Agency Representative	(print) Signatu	ıre					Date	
I agree that the above plan of services is a			ridual. This	service mo	dification ha	as been ap _l	proved by t	he
individual and included in the CSP mainta	ained in the Case Manager's record	d.						
CSB Rep/Case Manager (print)	Signature	Phon	e No.		Fax No.		Date	

☐ Initiate Waiver services									
☐ Service Modification	MD 147			0		CCD			
€ Add a service		iver Resi				CSB			
€ Increasing level/hours of service	Individual S	ervice Ai	utnoriza	ition Re	quest	CSB	provider #		
€ Decreasing level/hours of service□ Provider Modification (requires 2 ISARs)									
☐ End a service									
Lild a service									
Provider Name							Provide	r Number	,
Name:				Star	t:		End:		
Last,	First		MI		Date			Date	
Medicaid Number:									
CHECK SERVICE TO BE PROVIDED	ı		WEEKLY	YEARLY I	HOURS		0	MR USE C	NLY
Z8595 Supported Living / I n-l	Home								
☐ Z8551 Congregate (please sp	ecify below)								
☐ Group Home ☐ Group Adult Foster Care Home ☐ Assi	up Home for Children								
Sponsored Placement Othe		Hours /	/ week	x 52	= Yea	rly total (1)		
		+		_					
Enter periodic support hours									
	(if needed)	Hours /	/ week						
Enter total of periodic cupps	ort bours	=	:	_					
Enter total of periodic support regular hours		Hours /	/ wook	x 52	= Yea	rly total (2)		
Reason for this request:		i ilouis /	WCCK	X 02	_ 1Ca	ily total (<i>_</i>)		
Reason for this request.									
Check the allowable activities that are	included in the individ	lual's plan. I	ndicate the	total num	ber of hour	rs of progra	am time pe	r day.	
Training in Functional Skills			Sun	Mon	Tues	Wed	Thur	Fri	Sat
personal care and activities of	daily living;								
use of community resources;									
adaptive behavior for home and	d community enviro	nments							
Assistance and specialized sup	ervision								
(excluding nighttime) with									
personal care activities of daily living, use of o	community recourse	NC							
medication, med needs, monitor									
condition	g a py a								
travel to & from training sites a	nd community resou	ırces							
Nighttime Specialized Supervisi	on If applicable i	ndicate							
hours needed and provide explana		. Idioato							
' '									
What will staff do for Nighttime Sp	ecialized Supervisio	n?							
Trial viii olaii do ioi riigittiine op	Solulizou Supervisio								

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	d 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

☐ Initiate Waiver services ■ Service Modification

CSB	
CSB	provider #

€ Add a service	IVIR Walver Age	C3B			
€ Increasing level/hours of service	Individual Service	-	CSB provider #		
€ Decreasing level/hours of service			•		
Provider Modification (requires 2 ISARs)					
End a service					
Provider Name				Provider Number	
1 Tovider Ivairie				1 TOVIGET NUMBER	
Name:		Star		End:	
Last,	First	MI	Date	Date	
Medicaid Number:					
SERVICE TO BE PROVIDED		HOURS NEEDE	D	OMR USE ONLY	
Z9421 Respite					
☐ In-Home					
Center-Based					
Out-of-Home					
Residential					
Reason for this request:					
Check the allowable activities that are	included in the individual's pla	an.			
(Not available to individuals living with p Respite hours per year, including CD R		ovided by Foster/Family	Care providers	to their own resident. Maximum 72	
Assistance with:					
activities of daily living;					
monitoring health status & physic	ical condition;				
medication and/or other medica	I needs;				
meal preparation & eating;					
housekeeping activities;					
participating in recreational activ	vities: and/or				
appointments/meetings					
Support:					
to assure health & safety of the	individual				
Comments:					
lame of Provider Agency Representative	· ·	nature		Date	
l agree that the above plan of services is a included in the CSP maintained in the Cas		eds of this individual. This	service plan has	s been approved by the individual an	
CSB Rep/ Case Manager (print)	Signature	Phone No.	Fax I	No. Date	
COLD DED/ CASE MADADEL COURT	Signature	PHONE INO	L S X I	ou Dale	

 □ 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 Wai Individual	ver Suppo Service Au					SB		
Provider Name							Provid	er Numb	er
Name:				Sta	art:		End:		
Last,	First		MI			Date		Date)
Medicaid Number:									
CHECK SERVICE TO BE PROVIDED		WEEKLY /	YEARLY H	OURS C	OR UNITS		OMR	USE ONL	Y
Z8597 Supported Emp, Individua	al Placement								
	ar racomon	Hours / w	eek x	52 =	Yearly	total			
Z8598 Supported Emp., Group		Units / we	ek v	52 =	Yearly	total			
Reason for this request:		OTIRES / WC	JOK X	02 -	rearry	totai			
•									
Check the allowable activities that are in	cluded in the indi	vidual's plan.							
☐ Individualized assessment & dev☐ Individualized job development☐ On-the-job training in work & wor☐ Ongoing evaluation, supervision☐ Ongoing support services necess☐ Training in related skills essentia☐ Travel with the individual to and f☐ Other:	k-related skills i and monitoring sary to assure jo to obtaining &	required to pe of job perforn ob retention retaining emp	erform the mance bey	job yond su		·	oilities		
There is documentation in the rec (for those less than 22 years) nor	ord that Suppo from Departme	orted Emplogent of Rehab	yment Se ilitative S	rvices Services	cannot be s?	obtaine es 🗌 N	d from th o	e school	system
Record the number of hours per of (for biweekly/varied schedules, draw a line	-	-	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 a freedom if billing for this time; can be included bill for a 3-unit day, a minimum of 7 hrs required; does not include training related r	ed up to 25% of the of other allowable	le activities is							
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

☐ Initiate Waiver services			
□ Service Modification€ Add a service	MAD MAGASAS T		
€ Increasing level/hours of service		herapeutic Consultation vice Authorization Request	CSB
€ Decreasing level/hours of service	iliaividuai 3ei v	vice Authorization Nequest	CSB provider #
□ Provider Modification (requires 2 ISARs)□ End a service			
a End a service			
Provider Name			Provider Number
. Tevider Hame			
Name:	First	Start:	End: Date
Last, Medicaid Number:	FIISI		ay be provided in the absence of other
CHECK SERVICE TO BE PROVIDE	D	HOURS NEEDED	OMR USE ONLY
Z8565 Therapeutic Consultation		HOOKS NEEDED	CIVIL USE ONE!
Behavioral			
☐Psychological☐Speech			
Occupational			
Physical			
☐Recreational☐Rehabilitation Eng	ineering		
	incerning		
Reason for this request:			
Check the allowable activities that ar	e included in the individual	's plan. Indicate the approximate total numb	per of hours.
(May not be direct therapy, evaluate	tions, or services availabl	le through the Medicaid State Plan.)	Hours needed in
Assessment/evaluation:		,	each area
interviewing to identify issues to be	addressed/desired outcomes	s	
Training, consultation & techni		-	
☐ training in better supporting the indiv ☐ reviewing documentation & evaluati	_	servations of environment/routines/interactions	
demonstrating/training in specialized		r use of assistive devices	
		ctives as part of the overall individua	al l
program planning process:	•	•	
designing & developing a written Su			
☐ making recommendations related to	specific devices/technology	or adapting other training programs/activities	
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