

- Initiate CMH Program services
- Service Modification
 - Add a service
 - Increasing level/hours of service
 - Decreasing level/hours of service
- Change in SF (requires 2 ISARs)
- End CD service

Case Management/Transition
Coordination agency

CMH Program Consumer-Directed Companion Services Individual Service Authorization Request

Provider # _____

Name: _____ Medicaid No. _____
Last, First MI

Address: _____
Street/apt. City, State Zip Code

Phone Number: _____ Social Security Number: _____

Service Facilitator (SF) _____ Provider No. _____ Reassessment? Yes ___ No ___
 SF agency, if applicable _____

Will the individual be directing his or her own services? Yes No
 If NO, name and relationship of responsible family caregiver: _____

SERVICE REQUESTED	WEEKLY / YEARLY HOURS	DMAS USE ONLY
Fill in applicable dates: SF Start Date: _____ <small>CD Services start date may not precede this date</small> SF End Date: _____ S5136 – CD Companion Start Date: _____ S5136 – CD Companion End Date: _____ Total number of persons with disabilities in this residence: _____	_____ Hours / week x 52 = _____ Yearly total (1)	

Reason for this request: _____

Check the allowable activities included in the ISP. Indicate the total number of hours per day of expected CD Companion Services.

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

Comments: _____

List any other AD or CD Companion Services Providers: _____
 Assurance that total of all AD and CD Companion services hours does not exceed 8 hrs in any 24hr. period. Yes No

Signature of Services Facilitator 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
 DMAS 819