SUBMIT SERVICE AUTHORIZATION:
Fax: 217-528-9849 or 570-558-5570
Email: budgetsIL@mycil.org

ACES$ ILLINOIS

SERVICE AUTHORIZATION FORM

CONSUMER INFORMATION

** Children and Young Adults: Parents/Step -parents/Guardians cannot work as PSW for consumers under the age of 18.

Waiver Type*:(check one) ☐ Adult HCBS ☐ Children and Young Adults HCBS

Consumer Name : First | Middle | Last Consumer Number:

Phone Number: Social Security Number RIN Number

Email Address: Self-Directing Services: ☐ Yes ☐ No

If no, please fill out the **Self Directed Assistant Section Below**

Self-Directed Assistant Information

Self-Directed Assistant Name: Agency:

Self-Directed Assistant Email: Phone Number:

Employer Information

Who is designated as the Employer?: ☐ Consumer ☐ Someone Else Relationship to Consumer:

List Employer Information Below

Employer Name: First | Middle | Last

Employer Phone Number : Employer Email :

SERVICE AUTHORIZATION INFORMATION

Purpose for Authorization: ☐ New Consumer ☐ Change to Services*

Monthly Service Start Date: Monthly Service End Date:

	PSW Name	SSN	CODE	Hourly Pay Wage	Cost to You *Cost to You = Hourly Wage x 1.045		Hours Approved per Month		Maximum Monthly Dollar Amount
1.				$	$	X		= $	
2.				$	$	X		= $	
3.				$	$	X		= $	
4.				$	$	X		= $	
5.				$	$	X		= $	
6.				$	$	X		= $	
7.				$	$	X		= $	
8.				$	$	X		= $	

** Pay wage changes must be received by the 4th of the month to take effect for that month's payroll. Pay wage changes received after the 4th will take effect the following month.*

Total Monthly Amount = $

Termination of Service Effective Date: Reason for Termination:

I herby authorize this service authorization and understand it is my responsibility to monitor and approve the provided budget for the individual consumer's service plan and monthly service maximum. I fully understand that failure to comply with the provided budget could result in the interruption of payroll for the personal support worker(s) until over budget issues are fully resolved.

Employer Signature Date

SDA Signature Date

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Date Received: Staff Initials and Date Processed: