DEPARTMENT OF HEALTH SERVICES
Division of Long Term Care
F-20445 (07/2014)

STATE OF WISCONSIN

INDIVIDUAL SERVICE PLAN – MEDICAID WAIVERS

1 Waiver Program	1a Plan Type	1b **Current** ISP Date	2 Medicaid ID or MCI Number (as applicable)
☐ CIP II ☐ CIP II CRI.MFP ☐ CIP II-DIV ☐ COP-W ☐ CIP 1A ☐ CIP 1B ☐ CLTS	☐ New ☐ Recertification ☐ Six Month Review ☐ ISP Update		

3 Individual's Name	4 Address (street)	4a City, State, Zip Code	4b Date of Birth

5 Mailing Address (If Different)	6 Telephone	7 Email	8 **Initial** Service Plan Development Date	9 Functional Screen Date

10 Cost Share Amount	11 Level of Care	12 Parental Fee (If Applicable)	13 Personal Discretionary Funds Available	14 [Reserved]	15 Start Up/One-Time Cost -Total	16 Waiver Cost/Day Total

17 Prior Living Arrangement-HSRS Code (CLTS- N/A)	18 Prior Living Arrangement-Name/Type	19 Current Living Arrangement-HSRS Code (CLTS- N/A)	20 Current Living Arrangement-Name/Type

21 Waiver Agency	22 Agency Telephone No.	23 Support & Service Coordinator/Care Manager (SSC/CM)	24 SSC/CM Telephone No./Ext.

25 Mailing Address (Agency)	City	State	Zip	26 Mailing Address (SSC/CM)

27 E-mail Address (Agency)	28 E-mail Address (SSC/CM)

29 Name – Parent(s) or Guardian	30 Telephone No. (Home)	31 Telephone No. (Work)

32 Mailing Address (Street/PO Box)	33 City	34 State	35 Zip

36 E-mail Address	37 Telephone No. (Cell)

IN CASE OF EMERGENCY, NOTIFY: 38 Name	39 Telephone (Preferred/Primary No.)	40 Email Address

41 Address	42 City	43 State	44 Zip	45 Relationship

62 Service Code #	63 Service Name	64 Outcome No. (F-20445A #5)	65 Service Provider Name Address and Telephone No. (Email, cell phone no., if known)	65a Start Date	65b End Date	66 Unit Cost ($/hr; day)	67 Authorized Units of Service and Frequency (#/day or week or month)	68 Daily Cost (total yearly ÷ 365 days)	69 Funding Source

70 PARTICIPANT INFORMED – R IGHTS AND CHOICE (Review REQUIRED at initial plan development and recertification.)

☐ I have been informed that I have a **RIGHT TO CHOOSE** between a nursing home or ICF-IDD and community services through a Medicaid Home and Community Based Service Program.

☐ I have been informed of my **CHOICES** in the waiver programs, including my right to **CHOOSE the TYPE OF SERVICES** I receive under my service plan.

☐ I understand that I have CHOICES in the waiver programs, including my right to CHOOSE from available, qualified providers that will provide the services outlined in my plan.

☐ I have been informed verbally and in writing of my rights and responsibilities in the Medicaid Waiver Programs and I understand these rights and responsibilities.

☐ I have been informed verbally and in writing of my **RIGHT TO REQUEST A HEARING** should I disagree with decisions made about my **ELIGIBILITY** to participate in the HCBS program.

☐ I have been informed verbally and in writing of my **RIGHT TO REQUEST A HEARING** should I disagree with decisions made that would **DENY**, **REDUCE OR TERMINATE** the services I receive.

☐ By **my signature** below I indicate I have chosen to accept community services through a Medicaid Home and Community Waiver Program.

71 UPDATE/REVIEW VERIIFICATION - APPLIES TO PLAN REVIEW OR ISP UPDATE ONLY

☐ The SIX MONTH ISP Review was completed with the participant/guardian on the date below and there are no changes to the ISP at this time.

☐ The SIX MONTH ISP Review was completed with the participant/guardian on the date below and agreed upon changes to the ISP are included herein.

☐ The ISP was UPDATED on the date below to reflect changes (additions, increases or reductions) to planned services or providers or to units/frequency of service.

SIGNATURES: ISP Signature Requirements apply at the time of plan development, review and recertification.

SIGNATURE - Participant	Date Signed	**SIGNATURE –** Support and Service Coordinator/Care Manager	Date Signed
SIGNATURE – Guardian/Authorized Representative/Parent	Date Signed	**SIGNATURE -** Guardian/Authorized Representative/Parent	Date Signed
SIGNATURE - Witness	Date Signed	**SIGNATURE –** Witness	Date Signed

DISTRIBUTION: Original – DHS; Copy - County Care Manager/Support and Service Coordinator; Copy – Individual; Copy - Authorized Representative

CIP II/COP-W CBRF VARIANCE REQUEST [CHECK (√) THE TYPE OF VARIANCE REQUESTED) NOT APPLICABLE TO CIP 1A/B OR CLTS

☐ A variance to the 20-bed CBRF size limitation for an individual that is elderly

☐ A variance to allow waiver funding for an individual that is elderly to reside in a CBRF connected to a nursing home

BY SIGNING BELOW, THE SUPPORT AND SERVICE COORDINATOR / CARE MANAGER ATTESTS TO THE FOLLOWING:

1. The environment is non-institutional and the facility operates in a manner than enhances resident dignity and independence, **and**

2. The facility is the preferred residence of the applicant/participant or his/her legal representative.

SIGNATURE - Participant	Date Signed	**SIGNATURE –** Support and Service Coordinator/Care Manager	Date Signed
SIGNATURE – Guardian/Authorized Representative/Parent	Date Signed	**SIGNATURE -** Guardian/Authorized Representative/Parent	Date Signed
SIGNATURE - Witness	Date Signed	**SIGNATURE –** Witness	Date Signed

DISTRIBUTION: Original – DHS; Copy - County Care Manager/Support and Service Coordinator; Copy – Individual; Copy - Legal Representative