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| DEPARTMENT OF HEALTH SERVICES Division of Medicaid Services  F-20445 (09/2022) |  | STATE OF WISCONSIN |

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| INDIVIDUAL SERVICE PLAN – children’s LONG-TERM SUPPORT programs | | | | | | | | | | | | | | | | | |
| 1 Program(s)  CLTS Waiver Program  CCOP | 1a Plan Type  New  Recertification  Six-Month Review  Update | | | | | | | 2 **Initial** **ISP**  Development Date | | | 3 **Current ISP**  Completion Date | | | | | | 4 MCI Number |
| **PARTICIPANT INFORMATION** | | | | | | | | | | | | | | | | | |
| 5 Participant’s Name | | | 6 Address (street) | | | | | | 6a City, State, Zip Code | | | | | | | 7 Date of Birth | |
| 8 Mailing Address (if different from street address) | | | 9 Telephone | | | | 10 Email Address (optional) | | | | | | | | | 11 Functional Screen Date | |
| **PROGRAM INFORMATION** | | | | | | | | | | | | | | | | | |
| 12 Medicaid Cost Share (if any) | | | | | 13 Estimated Parental Payment (if any) | | | | | 14 Total Cost/Day | | | |
| 15 Current Living Arrangement (name or type) | | | | | | | | | | | | | | | | | |
| **AGENCY INFORMATION** | | | | | | | | | | | | | | | | | |
| 16 Waiver Agency | | | | 16a Agency Telephone | | 17 Support and Service Coordinator (SSC) | | | | | | | | | 17a SSC Telephone No./Ext. | | |
| 16b Agency Mailing Address (street, city, state, Zip code) | | | | | | 17b SSC Mailing Address (if different from agency’s) | | | | | | | | | | | |
| 16c Agency Email Address (optional) | | | | | | 17c SSC Email Address | | | | | | | | | | | |
| **PARENT/GUARDIAN INFORMATION** | | | | | | | | | | | | | | | | | |
| 18 Name – Parent(s) or Guardian | | | | | | 19 Email Address(es) | | | | | | | | | | | |
| 20 Mailing Address (if different from participant’s) | | | | | | 20a City, State, Zip Code | | | | | | | | | | | |
| 21 Telephone (cell) | | 21a Telephone (2nd cell, if applicable) | | | | 21b Telephone (home) | | | | | | | 21c Telephone (work) | | | | |
| **IN CASE OF EMERGENCY, NOTIFY:** | | | | | | | | | | | | | | | | | |
| 22 Name | | | | | | 23 Telephone (preferred/primary) | | | | | | 24 Email Address | | | | | |
| 25 Address (street, city, state, Zip code) | | | | | | | | | | | | 26 Relationship | | | | | |

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**36** **Outlier Rate:**  Check this box when any service listed on this ISP uses a DHS-approved outlier rate.

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| **37 PARTICIPANT-INFORMED RIGHTS AND CHOICE**  **Review Required at initial plan development and recertification. All lines apply to both CLTS Waiver and CCOP, unless otherwise indicated.**  I have been informed that I have a **right to CHOOSE** between institutional services and community services through a Medicaid Home and Community-Based Services (HCBS) Program (i.e., the CLTS Waiver Program). (This line does not apply to CCOP-only plans.)  I have been informed of my **CHOICES** through the children’s long-term support programs (i.e., the CLTS Waiver Program and/or CCOP), including my right to **CHOOSE the** **type of services** I receive under my service plan.  I understand that I have **CHOICES** through the children’s long-term support programs, including my right to **CHOOSE** from available, qualified providers who will provide the services outlined in my plan.  I have been informed verbally and in writing of my rights and responsibilities in the children’s long-term support 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 children’s long-term support programs.  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.  I have chosen to accept community services through a Medicaid HCBS Waiver Program (i.e., the CLTS Waiver Program). (This line does not apply to CCOP-only plans.)  **38 REVIEW/UPDATE VERIFICATION – ONLY APPLIES TO PLAN REVIEW OR ISP UPDATE**  The six-month ISP Review was completed with the participant and family 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 and family 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 signatures are required at the time of plan development, review, and recertification.**

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| **SIGNATURE** – Participant (if at least 14 years old) | Date Signed | **SIGNATURE** – Support and Service Coordinator | Date Signed |
| **SIGNATURE** – Parent/Guardian/Authorized Representative | Date Signed | **SIGNATURE** – Parent/Guardian/Authorized Representative | Date Signed |
| **SIGNATURE** – Witness (see instructions) | Date Signed |  | |

**DISTRIBUTION:** Original – Support and Service Coordinator/Participant File; Copy – Participant/Parent/Guardian/Authorized Representative