|  |  |  |  |
| --- | --- | --- | --- |
| **DEPARTMENT OF HEALTH SERVICES**  **STATE OF WISCONSIN**  Division of Medicaid Services  F-20445A (05/2022) | | | |
| **INDIVIDUAL SERVICE PLAN — OUTCOMES — CHILDREN’S LONG-TERM SUPPORT PROGRAMS** | | | |
| 1. Program(s)  CLTS Waiver  CCOP | | 2. Name — Support and Service Coordinator, Agency | |
| 3. Name – Participant | | | |
| 4. Outcome  Number | 5. Desired Outcome(s) Addressed in Service Plan | 6. Outcome Status or Progress Update | 7. Date |

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**8. PARTICIPANT-INFORMED INFORMATION SHARING**

|  |  |
| --- | --- |
| Check all of the applicable **CLTS waiver-funded** essential services included on the current plan: | |
| Adult family home  Child care  Child foster care  Communication assistance for community inclusion\*  Community/competitive integrated employment  Community integration services  Counseling and therapeutic services  Daily living skills training  Day services | Discovery and career planning\*  Grief and bereavement counseling  Health and wellness\*  Mentoring  Participant and family-direction broker services  Personal supports (excluding routine home care/chore services/pest control)  Respite  Safety planning and prevention\* |

Providers of the services indicated above that meet the definition of an essential service provider will receive a copy of this document (F-20445A), and they will be asked to sign and return a copy to the waiver agency.

\*Components of this service may have providers that meet the definition of an essential service provider.

|  |  |  |  |
| --- | --- | --- | --- |
| **9. PROVIDER SIGNATURE**  Waiver agencies must indicate **one** of the following:  This information is being shared with service providers who have been newly added to the participant’s ISP.  This information is being shared with service providers at the participant’s annual review. | | | |
| By signing below, providers of CLTS Program supports and services acknowledge receiving a copy of this document. | | | |
| Provider Name (agency) | | Service Category (from field 8) | |
| Name of Individual Signing (please print) | **SIGNATURE** | | Date Signed |