

DEPARTMENT OF HEALTH SERVICES

Division of Long Term Care
F-20445 (08/2008)

STATE OF WISCONSIN

INDIVIDUAL SERVICE PLAN – MEDICAID WAIVERS

1 Waiver Program <input type="checkbox"/> CIP II <input type="checkbox"/> COP-W <input type="checkbox"/> CIP 1A <input type="checkbox"/> CIP 1B <input type="checkbox"/> BIW <input type="checkbox"/> COR <input type="checkbox"/> CLTS DD <input type="checkbox"/> CLTS MH <input type="checkbox"/> CLTS PD				1a Plan Type (Check ALL That Apply) <input type="checkbox"/> New <input type="checkbox"/> Six Month Review <input type="checkbox"/> Annual Recertification <input type="checkbox"/> CLTS Crisis <input type="checkbox"/> Update <input type="checkbox"/> CLTS Pilot				2 Medicaid ID Number	
3 Individual's Name			4 Address (street)			4a City, State		4b Zip Code	
5 Mailing Address (If Different)			6 Telephone		7 E-Mail		8 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		18 Prior Living Arrangement-Name/Type		19 Current Living Arrangement- HSRS Code		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 No. (Home)		40 Telephone No. (Work)		
41 Address				42 City		43 State	44 Zip	45 Relationship	

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- I have been informed that I have a choice between an ICF-MR or nursing home (dependent on waiver type) and community services through a Medicaid Home and Community Waiver Program.
- I have been informed of and understand my choices in the waiver programs, including approval or rejection of the services and providers listed on this service plan.
- I have been informed of and understand my rights and responsibilities in the Medicaid Home and Community Waiver Programs.
- I was informed verbally and in writing of my rights and responsibilities.
- By my signature below I indicate I have chosen to accept community services through a Medicaid Home and Community Waiver Program.

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: DHS, County Care Manager/Support and Service Coordinator, Individual, Authorized Representative

CIP II/COP-W CBRF Variance Request [Check (√) the type of variance requested]

- 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.

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