
INDIVIDUAL SERVICE PLAN (ISP) & ISP – INDIVIDUAL OUTCOMES

☞ PURPOSE OF THE ISP & ISP – INDIVIDUAL OUTCOMES

The ISP is a summary of the individual's package of supports and services. It should be consistent with information about needs, services and preferences identified in the Assessment/Supplement and should reflect both formal and informal supports. It is also a document that lists the things that are important to the individual and what he/she hopes to maintain or achieve as it pertains to his/her health, welfare, socialization, etc.

☞ COMPLETING THE ISP & ISP-INDIVIDUAL OUTCOMES

The care manager must develop an ISP for the certification of all waiver program applicants. The ISP should be updated as needed (see ISP Updates for more information).

The ISP should be filled out *completely*. Key items **that are frequently missed** include:

- New Plan or Annual Recertification or Plan Update Box
- Cost Share Amount Box
- Where Cost Share will be paid (direct to vendor or to county waiver agency) (if applicable)
- Waiver Cost/Day/Total Box (this is the daily cost total for waiver services only)
- SPC Code Numbers (for waiver services)
- Start Dates (for waiver services)
- Daily Costs (for waiver and COP services)
- Dates and Signatures
- Service Plan Development Date
- Attributing a listed waiver service to the individual's identified outcome
- Column 7 & 8 on the ISP – Individual Outcomes page

Waiver participants must have their rights and responsibilities explained to them. Care manager resources include Appendix M-1 of the Medicaid Waivers Manual (Participants' Rights and Responsibilities), F-20985 <http://dhs.wisconsin.gov/forms1/f2/f20985.pdf> and, The Wisconsin Medicaid Program – Eligibility and Benefits February 2006 - PHC 10025 (Rev. 02/06).

Note: The Bureau of Long Term Support (BLTS) changed the format of the Individualized Service Plan (ISP) effective January 1, 2007. In addition to changing the general format, the ISP also gives care managers a place to show a “link” between the service that is being authorized and the participant’s individualized outcome he/she hopes to achieve.

NOTES

INDIVIDUAL SERVICE PLAN – MEDICAID WAIVERS

1 Waiver Program <input type="checkbox"/> CIP II <input checked="" 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 checked="" 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 Ada Smith		4 Address (street) 10 N. Elm Street Apt. 4		4a City, State Many Lakes, WI		4b Zip Code 55555			
5 Mailing Address (If Different) SAME		6 Telephone (441) 419-4949	7 E-Mail		8 Service Plan Development Date Date waiver plan first disc. w/ applicant.		9 Functional Screen Date 10/8/09		
10 Cost Share Amount \$0.00	11 Level of Care ICF Level 2	12 Parental Fee (If Applicable)	13 Personal Discretionary Funds Available	14 [Reserved]	15 Start Up/One-Time Cost -Total \$55.00	16 Waiver Cost/Day Total \$13.37 -waiver \$ only			
17 Prior Living Arrangement- HRSR Code 30	18 Prior Living Arrangement-Name/Type Meadowview Apartments		19 Current Living Arrangement- HRSR Code 30	20 Current Living Arrangement-Name/Type Meadowview Apartments					
21 Waiver Agency Northwood County Social Services		22 Agency Telephone No. (123) 456-7890		23 Support & Service Coordinator/Care Manager (SSC/CM) Ivanna Help		24 SSC/CM Telephone No./Ext. (123) 456-7892			
25 Mailing Address (Agency) 123 Main Street	City Many Lakes	State WI	Zip 12345	26 Mailing Address (SSC/CM) 123 Main Street Many Lakes, WI 12345					
27 E-mail Address (Agency) northwoodsds@ds.co.northwoods.wi.us				28 E-mail Address (SSC/CM) ihelp@dss.co.northwoods.wi.us					
29 Name – Parent(s) or Guardian self				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:				39 Telephone No. (Home) (123) 456-7890		40 Telephone No. (Work) N/A			
38 Name Beverly Jones				42 City Many Lakes		43 State WI	44 Zip 12345	45 Relationship Daughter	
41 Address 1234 Old Home Road				42 City Many Lakes		43 State WI	44 Zip 12345	45 Relationship Daughter	

62 Service Code#	63 Service Name	64 Outcome No. (DDE-445a#5)	65 Service Provider Name Address and Telephone No. (e-mail, 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
	Housing		Ada Smith						SS
104.23	SHC	1	Northwoods Helpers 350 Perkins Drive Many Lakes, WI	Service Plan Dev. Date		\$10.45/hr.	4 hrs/week	\$5.96/day	COP-W
112.46	PERS	2	Northwoods Hospital 82 Brooks Street Many Lakes, WI	Service Plan Dev. Date		\$55.00 installation \$30.00 /mo.	Monthly	.12/day 1x cost .99/day	COP-W
604	CM		Northwood Social Services 123 Main Street Many Lakes, WI	Service Plan Dev Date		\$35.00/hr	3 hrs/month	\$3.45	COP-W
402	HDM	3	Commission on Aging 123 Main Street Many Lakes, WI	Service Plan Dev. Date		\$4/meal	5 meals/week	\$2.85	COP-W
	MAPC RN MD Meds Equipmt Tran MD Meals Soc. Sup Rx monit		VNA VNA Dr. Feelgood @ Brownberry Clinic Pill R Us Pills R Us – toilet guardrails COA Flo Buckley Father O'Malley Beverly Jones				2 visits/wk 1 hr/2x a month 1 visit/6 months monthly 1 time As needed 1 meal/week 1 visit/month weekly		Medicaid Medicaid Medicaid Medicare Medicaid Medicaid Volunteer Volunteer Volunteer

- 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 10/14/09	SIGNATURE – Support and Service Coordinator/Care Manager	Date Signed 10/14/09
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

INDIVIDUAL SERVICE PLAN – INDIVIDUAL OUTCOMES

1. Waiver Program: <input type="checkbox"/> CLTS Waiver (Indicate Target Group): <input type="checkbox"/> CIP 1A <input type="checkbox"/> CIP 1B <input type="checkbox"/> BIW <input type="checkbox"/> DD <input type="checkbox"/> CIP II <input type="checkbox"/> MH <input checked="" type="checkbox"/> COP-W <input type="checkbox"/> PD <input type="checkbox"/> COR		2. Name - Support and Service Coordinator/Care Manager, Agency Ivanna Help - Northwoods DSS	
3. Name - Applicant/Participant Ada Smith		4. Medicaid ID Number	
5. Outcome Number	6. Desired Outcome(s) Addressed in Service Plan	7. Outcome Status or Progress Update	8. Date
1	<i>My house is a mess. I hate that I can no longer keep my house up.</i>	<i>New. Northwood Helper workers will assist with vacuuming, dusting, bathroom clean-up and laundry. Grocery shopping, as needed</i>	<i>(Service date)</i>
2	<i>I don't want to feel nervous about the possibility of falling and not being able to reach anyone if I have an emergency.</i>	<i>New. Northwood Hospital has Personal Emergency Response System. Will contact and relay preference of bracelet type as stated by Ada Smith.</i>	<i>(Service date)</i>
3	<i>I have been losing weight lately and my doctor is concerned too. I need to start eating better.</i>	<i>New Commission on Aging – provides Home Delivered Meals. Flo Buckley, neighbor – arrange to bring over/share Sunday meal</i>	<i>(Service date)</i>
4	<i>My spiritual life is important to me and I would like to continue receiving communion.</i>	<i>On-going. Father O'Malley, parish priest.</i>	<i>On-going</i>
5	<i>It is hard for me to keep track of my pills since the prescription keeps changing. I feel better about taking my pills if someone else helps with putting my pills in my pill box.</i>	<i>On-going. Beverly Jones, daughter</i>	<i>On-going</i>

DEPARTMENT OF HEALTH SERVICES

Division of Long Term Care
F-20445 (08/01/06)

STATE OF WISCONSIN

INDIVIDUAL SERVICE PLAN – MEDICAID WAIVERS

1 Waiver Program <input type="checkbox"/> CIP II <input checked="" 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 checked="" 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 John Brown			4 Address (street) 113 Maple Drive			4a City, State Allentown, WI		4b Zip Code 54960	
5 Mailing Address (If Different)			6 Telephone (608) 2739132		7 E-Mail		8 Service Plan Development Date 9/4/09	9 Functional Screen Date 9/4/09	
10 Cost Share Amount \$30.00	11 Level of Care ICF Level 2	12 Parental Fee (If Applicable)	13 Personal Discretionary Funds Available \$65.00		14 [Reserved]	15 Start Up/One-Time Cost -Total \$55.00	16 Waiver Cost/Day Total \$52.28		
17 Prior Living Arrangement- HSRS Code 61	18 Prior Living Arrangement-Name/Type Sunnyside CBRF		19 Current Living Arrangement- HSRS Code 61		20 Current Living Arrangement-Name/Type Sunnyside CBRF				
21 Waiver Agency Blue County DHS			22 Agency Telephone No. (608) 273-2100		23 Support & Service Coordinator/Care Manager (SSC/CM) Jean Thomas		24 SSC/CM Telephone No./Ext. (608) 271-2105		
25 Mailing Address (Agency) PO Box 732		City Allentown	State WI	Zip 54960	26 Mailing Address (SSC/CM) PO Box 732 Allentown, WI 54960				
27 E-mail Address (Agency) bluedhs@dhs.co.blue.wi.us				28 E-mail Address (SSC/CM) jthomas@dhs.co.blue.wi.us					
29 Name – Parent(s) or Guardian Self				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)	
Mary Douglas				(608)743-2915		(608) 255-1133			
41 Address 987 Every Street			42 City Rounder		43 State WI	44 Zip 55554	45 Relationship Daughter		

62 Service Code#	63 Service Name	64 Outcome No. (DDE-445a#5)	65 Service Provider Name Address and Telephone No. (e-mail, 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
506.61	Room/ Board	1	Sunnyside CBRF 113 Maple Drive Allentown, WI 54960	9/4/09		\$807.00/mo \$ 11.00/mo \$818 Total	7 days/wk 7 days/wk	\$.36	SS COP
506.61	Care/ Supervisn	1,2	Sunnyside CBRF 113 Maple Drive Allentown, WI 54960	9/4/09		\$1500/mo	7 days/wk	\$49.32	COP-W
604	CM	5	Blue County DHS PO Box 732 Allentown, WI 54960	9/4/09		\$60/hr	2 hr/mo	\$3.95	COP-W
095.01	Cost share		John Brown pays cost share directly to county	9/4/09		\$30.00/mo	Monthly		SS
	Pers Allow.		John Brown	9/4/09		\$65.00/mo	Monthly		SS
	MD visits Meds		Dr. Casey Walgreens				2x/ year monthly		Medicaid Medicare
	Social Support		Mary Douglas Pastor Goodguy				weekly 1 visit/month		Volunteer Volunteer

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SIGNATURE - Participant	Date Signed 9/14/09	SIGNATURE – Support and Service Coordinator/Care Manager	Date Signed 9/14/09
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

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1. Waiver Program: <input type="checkbox"/> CLTS Waiver (Indicate Target Group): <input type="checkbox"/> CIP 1A <input type="checkbox"/> CIP 1B <input type="checkbox"/> BIW <input type="checkbox"/> DD <input type="checkbox"/> CIP II <input type="checkbox"/> MH <input checked="" type="checkbox"/> COP-W <input type="checkbox"/> PD <input type="checkbox"/> COR		2. Name - Support and Service Coordinator/Care Manager, Agency Jean Thomas – Blue County DHS	
3. Name - Applicant/Participant John Brown		4. Medicaid ID Number	
5. Outcome Number	6. Desired Outcome(s) Addressed in Service Plan	7. Outcome Status or Progress Update	8. Date
1	<i>I want to live in a safe place with other people</i>	<i>New. Sunnyside CBRF (Care and Supervision)</i>	<i>(Service date)</i>
2	<i>I want to look good and feel clean</i>	<i>New. Sunnyside CBRF (Care and Supervision)</i>	<i>(Service date)</i>
3	<i>I like to go for rides in the country and stop for coffee at Suzy Q's</i>	<i>On-going. Mary Douglas, daughter</i>	<i>On-going</i>
4	<i>I like for my friend, Pastor Goodguy, to visit and talk about fishing and my church</i>	<i>On-going, Pastor Goodguy</i>	<i>On-going</i>
5	<i>I need someone to help me with my services</i>	<i>New. Care management, Jean Thomas</i>	<i>(Service date)</i>

For all waiver eligible individuals who reside in a substitute care living arrangement, a formula must be used to determine the amount of income available to pay room and board. The following is a link to the Department's form - Formula to Determine Amount of Income Available to Pay for Room and Board in Substitute Care:

<http://dhs.wisconsin.gov/forms1/F2/F20920.doc>

**FORMULA TO DETERMINE AMOUNT OF INCOME AVAILABLE
 TO PAY FOR ROOM AND BOARD IN SUBSTITUTE CARE**

Name – Applicant/Participant John Brown	Today's Date 09/4/09
1. Total income from all sources	\$914.00
2. Discretionary Income (not less than \$65)	\$65.00
3. Enter the difference between line 1 and line 2 here	\$849.00
4. Health insurance premium that the person pays out of pocket	\$0
5. Enter the difference between line 3 and line 4 here	\$849.00
6. Out of pocket medical/remedial expenses	\$12.00
7. Enter the difference between line 5 and line 6 here	\$837.00
8. Special exempt income	\$0
9. Enter the difference between line 7 and 8 here	\$837.00
10. Family Maintenance Allowance	\$0
11. Enter the difference between line 9 and line 10 here	\$837.00
12. Spousal income allocation	\$0
13. Enter the difference between line 11 and line 12 here	\$837.00
14. Cost Share or Spenddown obligation	\$30.00
15. Enter the difference between line 13 and line 14 here	\$807.00
16. Actual cost of room and board	\$818.00
17. Enter the difference between line 15 and line 16 here	\$11.00

User ID:ABC123
 Primary Person:JOHN BROWN

User Name:J DOE
 Case:0000000000

Quick Select: CASE/RFA
 Status: Open Mode: Ongoing

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▼ Eligibility (5)
▶ Run Results
▶ Eligibility Results
▼ Budgets
▪ BadgerCare Plus
▪ BadgerCare Plus Premium Summary
▪ SSI-Related Medicaid
▪ Family Planning Waiver
▪ MAPP
→ Community Waiver
▪ Institution Medicaid
▪ Family Care
▪ Caretaker Supplement
* FoodShare
▪ Child Care
▪ W-2
▶ Post Eligibility
* Confirmation Access
▶ Query
▶ Benefit Issuance

Community Waivers Budget	
Assistance Group Overview	
Assistance Group: MCWW- COMMUNITY WAIVERS COP	Sequence:
Benefit Begin Date: 09/04/09	Benefit End Date:
Determination Date: 09/04/09	
Results	
Assistance Group Status:PEND	Eligibility Status:PEND
Group Indicator:B	Community Waivers Eligibility Test: PEND
Individuals	
Community Waivers Name:JOHN BROWN	Community Spouse:
Community Waivers Eligibility Determination – Group B	
<p>Gross Earned Income: \$</p> <p>Gross Unearned Income: + 914.00</p> <p>Excess Self Employment Expenses: -</p> <p>Student Disregard: - _____</p> <p>Gross Income: \$ 914.00</p> <p>Categorically Needy Income Limit: \$ 1,911.00</p>	
Community Waivers Cost Share Budget	
<p>Gross Income: \$ 914.00</p> <p>COLA/DAC/WW Disregard: + _____</p> <p>Accumulated Gross Income: \$</p> <p>\$65 & ½ Disregard: -</p> <p>Special Exempt Income: -</p> <p>Basic Needs Allowance: - 817.00</p> <p>Special Housing Amount: - 55.00</p> <p>Family Maintenance Allowance: -</p> <p>Health Insurance Premium: -</p> <p>Medical/Remedial Expenses: - 12.00</p> <p>Cost Share: \$ 30.00</p>	

Assistance Group	Sequence	Updated on or by
MCWW- COMMUNITY WAIVERS COP		

NOTES

**AUTHORIZED REPRESENTATIVE DESIGNATION
MEDICAID COMMUNITY WAIVER PROGRAMS
Individualized Service Plan (ISP) ONLY**

(NOT to be used for financial eligibility documents: re. F-20919 or COP Cost Share Worksheets.)

Instructions: It is preferable to have the applicant/recipient sign documents relating to the Medicaid Community Waiver Programs with either a signature or mark to indicate his/her expressed preferences. (Those persons experiencing cognitive difficulties should be evaluated to see if another method is more appropriate.) However, the applicant/recipient may designate someone to sign the ISP on his/her behalf by completing the following form. If signed by an "X" or other mark, this form must be witnessed by two persons. The designated authorized representative and/or the case manager may act as witnesses should the applicant/recipient sign by an "X."

I authorize _____ to represent me and to act on my behalf and
(Print Full Name)
best interest in my application for the Medicaid Waiver Program. I have been consulted in the design of my service plan and my preferences are known to my representative.

_____	_____
SIGNATURE – Recipient / Applicant	Today's Date
_____	_____
SIGNATURE – Witness	Today's Date
_____	_____
SIGNATURE – Witness	Today's Date

I agree to represent _____ in his/her application to the Medicaid
(Print Applicant's Name)
Waiver Program. I have consulted with him/her and know what kinds of services are needed or desired.

_____	_____
SIGNATURE – Authorized Representative	Today's Date
_____	_____
SIGNATURE – Witness	Today's Date

**AUTHORIZED REPRESENTATIVE DESIGNATION
MEDICAID COMMUNITY WAIVER PROGRAMS
Individualized Service Plan (ISP) ONLY**

(NOT to be used for financial eligibility documents: re. F-20919 or COP Cost Share Worksheets.)

Instructions: It is preferable to have the applicant/recipient sign documents relating to the Medicaid Community Waiver Programs with either a signature or mark to indicate his/her expressed preferences. (Those persons experiencing cognitive difficulties should be evaluated to see if another method is more appropriate.) However, the applicant/recipient may designate someone to sign the ISP on his/her behalf by completing the following form. If signed by an "X" or other mark, this form must be witnessed by two persons. The designated authorized representative and/or the case manager may act as witnesses should the applicant/recipient sign by an "X."

I authorize Mary Jones to represent me and to act on my behalf and
(Print Full Name)

best interest in my application for the Medicaid Waiver Program. I have been consulted in the design of my service plan and my preferences are known to my representative.

X 10/28/09
SIGNATURE – Recipient / Applicant Today's Date

Robert Jones 10/28/09
SIGNATURE – Witness Today's Date

Jane Nichol 10/28/09
SIGNATURE – Witness Today's Date

I agree to represent John Doe in his/her application to the Medicaid
(Print Applicant's Name)

Waiver Program. I have consulted with him/her and know what kinds of services are needed or desired.

Mary Jones 10/28/09
SIGNATURE - Authorized Representative Today's Date

Jane Nichol 10/28/09
SIGNATURE – Witness Today's Date

**EXAMPLE OF COMPLETED
AUTHORIZATION TO REPRESENT**

SIGNATURES

- Both the applicant and the care manager must sign and date the ISP. The ISP is the contract between the individual and the county. It is the only document that contains the individual's signature as proof that s/he agrees with the plan.
- If a competent individual signs the ISP with an "X" or other mark, it is not required that the signature be witnessed. In general, the legal profession defines a signature as any mark intended to be a signature. However, best practice is to have the signature witnessed by a disinterested third party. It is strongly recommended that you develop a county waiver agency policy regarding this issue.
- Individuals can authorize another person to sign the ISP on their behalf by completing the Authorized Representative Form contained in the Medicaid Waivers Manual. The Authorized Representative Form only authorizes an individual to represent the person in the development of services and to sign the ISP on the individual's behalf. It does not impart legal authority, e.g. power-of-attorney. The individual's signature on the Authorized Representative Form should be witnessed. If the individual signs his/her name with an "X," then two witnesses are needed. The form should be kept in the individual's file but doesn't need to be sent in for review. Circle "authorized representative" on the ISP and have the authorized representative sign in the box. The Assessment/Supplement should contain a reference to the authorized representative.

ROOM AND BOARD

The Waiver Program cannot pay for room and board expenses. Waiver participants generally pay room and board expenses out of their personal income. **Room and board costs/amounts and the funding source should always be identified on the ISP.**

Financial eligibility should be established before determining the individual's ability to contribute toward room and board for those applicants/participants who reside in a substitute care facility. A formula currently located in the Medicaid Waivers Manual should be used to determine the amount of income the applicant/participant has available to pay towards room and board – the F-20920 form. Appendix 1 of Waiver Basics provides a Worksheet for breaking out the room/board and support/supervision expenses for CBRF residents. In addition, Appendix 1 also gives an example of a completed version of yet another type of worksheet for determining room/board for an applicant/participant who resides in substitute care.

DURABLE MEDICAL EQUIPMENT

The waiver program is able to purchase some adaptive aids that Medicaid does not cover, but Medicaid funding must always be explored before waiver funds can be used.

TIP: It is often helpful to show participants color catalogs with pictures of adaptive aids and equipment when discussing equipment options with them.

NOTES

VARIANCE REQUESTS

- **Adult Day Care – SPC 102** (if provided in or on the grounds of a nursing home)

If the Adult Day Care that is planned on being used is provided in a nursing home or on the grounds of a nursing home, the care manager must write a variance request. The variance should explain why a provider outside of an institution is not available or unable to be used by the participant. The variance must be person and provider specific. See example of a template that may be used to request this variance on the follow pages.

- **Institutional Respite – SPC 103.24**

Institutional respite can be used in the event of a sudden caregiver illness or caregiver injury, caregiver's need for respite, or for such purposes as a caregiver vacation. There is no maximum limit for the number of times institutional respite can be offered to the participant's caregiver. However, the actual respite stay must be short-term. Short term is defined as 28 consecutive days or less.

For new applicants requiring institutional respite, the care manager should include a variance request with the service plan packet. For existing participants, the request should be submitted prior to use of an institutional respite setting. Allowable settings for institutional respite include: Medicaid certified hospital; a Medicaid certified nursing home, or a Medicaid certified Intermediate Care Facility for the Mentally Retarded – (ICF-MR). Institutional respite requires prior approval, except in emergency situations.

Institutional respite services cannot be funded by the Waiver Program when a participant is without a place to stay. Nor can Waiver Program funding be used for institutional respite services when there is a lack of available staff from a provider agency to assist a participant.

Once prior approval of a specific institutional respite placement has been issued for a specific participant, subsequent placement of the same participant at the same respite setting does not require additional approval. However, if a different institutional respite setting is later sought for the participant, a new prior authorization must be obtained.

SPC 103.24 was developed so short-term respite stays in institutional settings could be billed to the waivers. Respite stays cannot exceed 28 consecutive days. All institutional respite stays require prior approval. If the requested respite stay is longer than 28 consecutive days the reason why this is needed should be included in the prior approval and will be discussed further with the care manager.

☞ **SAMPLE VARIANCE REQUEST for INSTITUTIONAL RESPITE**

To request a variance to the prohibition of institutional respite delivered in a Medicaid certified nursing home, hospital, or ICF-MR the following information needs to be submitted in writing for review.

1. The reason(s) for the request, and identification of the caregiver in need of respite.
2. The anticipated length of the respite placement.
3. A description of other community-based services of a similar nature available and specific barriers to using them.
4. A description of proposed services and the reason that setting was chosen.
5. A description of specific plans to address the limitation associated with the institutional setting.

The following is a link to the Department's forms for variance requests and home modifications – ramps:

Variance Request for Adult Day Care Located within or on the Grounds of a Nursing Home/ Institution

<http://dhs.wisconsin.gov/forms1/F2/F21056.pdf>

Variance Request for Institutional Respite

<http://dhs.wisconsin.gov/forms1/F2/F21059.doc>

Home Modification Request for a Ramp

<http://dhs.wisconsin.gov/forms1/F2/F21055.doc>

Examples of these templates are also on the following pages.

VARIANCE REQUEST FOR ADULT DAY CARE LOCATED WITHIN OR ON THE GROUNDS OF A NURSING HOME / INSTITUTION

A variance request is required under the Human Service Reporting System SPC 102. Use of this form is optional.

Name – CM/SSC or Social Worker	County/Agency	Date of Request
Email Address		Telephone No.
Name – COP-W / CIP II / CIP Participant		
Name – Adult Day Care (ADC)		
Address of ADC		
Nursing Home/Institution where ADC is Located		

Is the ADC a state certified facility: Yes No

- **If Yes, continue. If No, STOP.** This variance for ADC cannot be approved. Please choose another ADC that is state certified.

Cost per Day: _____ Proposed Frequency of Attendance at ADC: _____

Explain why an ADC provider outside of the nursing home/institution listed above is not available to this participant. (Example, no other ADC in the area, transportation to other ADCs in the area is not available, etc.)

Explain why an ADC provider outside of the nursing home listed above is not able to be used by this participant. (Example, the other ADCs in the area have too low of a staff/participant ratio for this participant's overall cognitive/care needs, the other ADCs do not have staff knowledgeable about the participant's medical and/or cognitive needs, the other ADCs are not wheelchair accessible, etc.)

NOTE: As required, please send (fax, mail, or email) to TMG or CIS a copy of an updated ISP containing this service addition.

<input type="checkbox"/> Approved <input type="checkbox"/> Denied	SIGNATURE – QAC or CIS	Date Approved/Denied
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Reason for denial (if applicable)

VARIANCE REQUEST FOR INSTITUTIONAL RESPITE

A variance request is required under the Human Service Reporting System SPC 103.24. Use of this form is optional.

Name – CM/SSC or Social Worker	County/Agency	Date of Request
Email Address		Telephone No.
Name – COP-W / CIP II / CIP Participant		
Name – Person Requiring Respite	Relationship to Participant	
Reason/Circumstance for Respite		
Name and Location of Hospital/Nursing Home/ICF-MR		

Is this facility certified for Medicaid? Yes No

If Yes, continue below. **If No, STOP**. Only facilities certified as Medicaid providers may be used for institutional respite. This variance for institutional respite cannot be approved. You must choose a Medicaid-certified facility.

Respite Cost per Day:

1. Anticipated length of respite placement—check one
 - One-time only request—specify dates/duration of respite stay:
 - Request for recurring stay at this facility. If yes, what is the frequency of the respite requested? [example, one weekend/month, or up to X days/year (specify planned days), etc]
2. Respite Request Narrative—address the following:
 - a. Why can't an AFH, CBRF or RCAC be utilized or, the hours of in-home respite or SHC increased, or other waiver services be provided to meet this need?
 - b. Describe this facility—why was this specific facility chosen?
 - c. What is being done or put in place to make the participant's stay at the facility as pleasant and non-disruptive as possible?

<input type="checkbox"/> Approved <input type="checkbox"/> Denied	SIGNATURE – QAC or CIS	Date Approved/Denied
Reason for denial (if applicable)		

HOME MODIFICATION REQUEST FOR A RAMP

A modification request is required under the Human Service Reporting System SPC 112.56. Use of this form is optional.

Name – CM/SSC or Social Worker	County/Agency	Date of Request
Email Address		Telephone No.

Name – COP-W / CIP II / CIP Participant

Does participant reside in a substitute care facility (AFH, CBRF, RCAC)? Yes No

- **If Yes, STOP.** As per the Medicaid Waiver Manual, “Excludes payments for modifications to a licensed or certified substitute care facility. In these facilities, repairs and/or modifications are a cost of facility operation.” As a result, this home modification request cannot be approved.
- **If No, continue.**

Does the participant live in a home owned by another person or in an apartment? Yes No

- If yes, has the dwelling owner approved of this construction? Yes No N/A

Explain how the proposed ramp will meet the participant’s assessed need or desired outcome.

NOTE: With this request, please send (fax or mail) a diagram of the proposed ramp to TMG or CIS, with a copy of an updated ISP (signed and dated by the participant) with this home modification added.

Specifics of Ramp and Landing

(To be completing by contractor or CM/SSC or social worker)

1. What is the measurement of the distance from the door threshold down to the ground? _____
2. What is the measurement of the distance between the door threshold and top landing? _____
3. What are the dimensions of the top landing? (should not be less than 5' x 5' or greater than 8' x 8') _____
4. What is the length of the ramp? _____
5. Are there resting/turning areas in the ramp? Yes No

If yes, what are the dimensions of those resting/turning areas? _____

6. What is the pitch of the ramp? (should not be steeper than 1:12" pitch)
 If the pitch is steeper than 1:12", please provide information as to how the participant will be able to manage the proposed steepness of the ramp. **NOTE:** Ramps steeper than 1:8" will not be approved. _____

7. Are there railings on both the landing and ramp? Yes No
8. Does the ramp have a raised edge? (**NOTE:** These are not needed if there are railings) Yes No N/A
9. Is there a need to have a solid surface landing at the end of the ramp for easy transferring/transitioning? Yes No

If Yes, What is the material of the landing? (cement, wood, other) _____

10. What are the dimensions of the landing at the end of the ramp? _____

Breakdown of Costs	Material:	Labor:
<input type="checkbox"/> Approved <input type="checkbox"/> Denied	SIGNATURE – QAC or CIS	
		Date Approved/Denied

Reason for denial (if applicable)

DOCUMENTATION OF RAMP CONSTRUCTION

The following is a means to document that the ramp was constructed according to local or state codes and regulations. It is not mandatory that this specific page be utilized; however, it is important that the information listed is documented within the file in some manner.

The Medicaid Waiver standards require that the ramp be built to all applicable local and state housing or building codes. The following statement may be used to meet this standard.

My signature attests that the wheelchair ramp and landing has been built in accordance with all applicable local and state housing or building codes and are subject to any inspection required by the municipality responsible for administration of the codes.

SIGNATURE – Builder/Contractor

Date Signed

Building Permit required? Yes No
Building Permit obtained? (if required) Yes No N/A
Builder Insured? (if applicable) Yes No N/A

SIGNATURE – CM/Social Worker

Date Signed

- **Permanent Residence in a CBRF of 21 beds or more (SPC 506.66, 506.67 or 506.68) for a participant age 65 or older and meets the target group definition of Frail Elder (FE)**

In order to use COP-W or CIP II funds for a participant age 65 or older who also meets the target group definition of FE, and resides permanently in a CBRF that is licensed for 21 beds or more, it is necessary for the county waiver agency to receive a **participant specific** written approval from the Department or it's designee.

The 2 criteria that have to be addressed when utilizing these large CBRF's are 1) is the environment non-institutionalized and operates in a manner that promotes resident dignity and independence, and 2) the CBRF is the preferred residence of the participant or his/her legal representative.

In order to receive the approval from it's designee, the county waiver agency should complete page 3B of the Individual Service Plan (DDE-445) and check the type of variance which is being requested. Both the participant/guardian and care manager must sign and date this variance request. Send the completed page 3B to TMG for approval.

- **Permanent Residence in a CBRF (of any bed size) - that is structurally connected to a nursing home (SPC 506.66, 506.67 or 506.68) for a participant age 65 or older and meets the target group definition of Frail Elderly (FE)**

In order to use COP-W or CIP II funds for a participant age 65 or older who also meets the target group definition of FE, and resides permanently in a CBRF (of any bed size) that is structurally connected to a Nursing Home, it is necessary for the county waiver agency to receive **participant specific** written approval from the Department or it's designee.

The 2 criteria that have to be addressed when utilizing these large CBRF's are 1) is the environment non-institutionalized and operates in a manner that promotes resident dignity and independence, and 2) the CBREF is the preferred residence of the participant or his/her legal representative.

In order to receive the approval from it's designee, the county waiver agency should complete page 3B of the Individual Service Plan (DDE-445) and check the type of variance which is being requested. Both the participant/guardian and care manager must sign and date this variance request. Send the completed page 3B to TMG for approval.

- **Permanent Residence in a CBRF of 21 beds or more that is not structurally connected to a nursing home (SPC 506.66, 506.67 or 506.68) for a participant who is age 64 or less and meets the target group definition of Physical Disability (PD)**

In order to use COP-W or CIP II funds for a PD participant who resides permanently in a CBRF that is licensed for 21 beds or more and that is not structurally connected to a

Nursing Home, it is necessary for the county waiver agency to receive written approval from the Department.

In order to receive the approval from the Department, the county waiver agency must write a variance request. The variance request should include the following information:

- a) The name, location and bed capacity of the facility.
- b) Information about how the facility's design and environment have been modified to suggest a home-like environment. In other words, how does the facility lessen the feeling to its residents of living in a large, congregate living space.
- c) Information about how the facility's programming and activities have been organized and developed to promote and enhance the participant's dignity, independence, privacy and choice.
- d) **If applicable**, if the CBRF indicates that they can provide services to persons who have an irreversible dementia such as Alzheimer's disease, there must be **documentation from the CBRF itself** that illustrates how they accommodate the special needs of those individuals.

Before the county waiver agency submits the variance request to the Department, the variance request must be reviewed and approved by the county's LTS/COP Planning Committee. Once approval is obtained from the county's internal LTS/COP Planning Committee, the county waiver agency should submit the variance to both 1) the Department, in care of the Bureau of Long Term Support (BLTS), and 2) the county's Regional Human Services Area Coordinator. BLTS will respond back to the county waiver agency in writing.

FYI:

- It is not necessary for a variance to be requested for each individual PD person who resides in the same CBRF over 21 beds. The variance approval from the Department will be facility specific. Once the approval is obtained for that specific facility, it is not necessary to write a new request if another PD individual is going to be residing at the same CBRF. However it is important to note that some variance approvals give specific information regarding the ability to fund more individuals at that specific facility. So it is important to read the variance approval in full and understand any restrictions that may be noted.

***Example for PD individuals:** Rock County wishes to use Apple Valley CBRF – a 32 bed CBRF located in Rock County for a person who is age 45 and meets the target group definition of PD. The CBRF is not structurally connected to a nursing home. Rock County writes a variance with all the needed information and follows all appropriate protocols to get it approved internally. Rock County then submits the variance to the Department. Upon review, the Department grants Rock County a variance to use waiver funds in this specific 32 - bed CBRF for persons who meet the definition of PD. Some time later, Rock County wishes to use this same CBRF for another person, age 53, who*

meets the target group definition of PD. It is not necessary for Rock County to submit another variance request to the Department. Reason: the Department has already granted Rock County permission to use this facility for those persons under the age of 65 who meet the target group of PD.

Example of both Frail Elder and PD who reside at the same CBRF that is 21 beds or more: *Example for PD individuals: Rock County wishes to use Apple Valley CBRF – a 32 bed CBRF located in Rock County for a person who is age 45 and meets the target group definition of PD. The CBRF is not structurally connected to a nursing home. Rock County writes a variance with all the needed information and follows all appropriate protocols to get it approved internally. Rock County then submits the variance to the Department. Upon review, the Department grants Rock County a variance to use waiver funds in this specific 32 - bed CBRF for persons who meet the definition of PD. Some time later, Rock County wishes to use this same CBRF for another person, age 82, who meets the target group definition of FE. The care manager needs to obtain a participant specific variance for the Frail Elder person. As a result, the care manager must complete page 3B of the ISP and send to TMG for approval.*

- If more than one county waiver agency uses the same CBRF that is 21 beds or more, each county waiver agency must receive either a variance approval from the Department, or a person specific variance, depending upon if the individual is PD or FE.

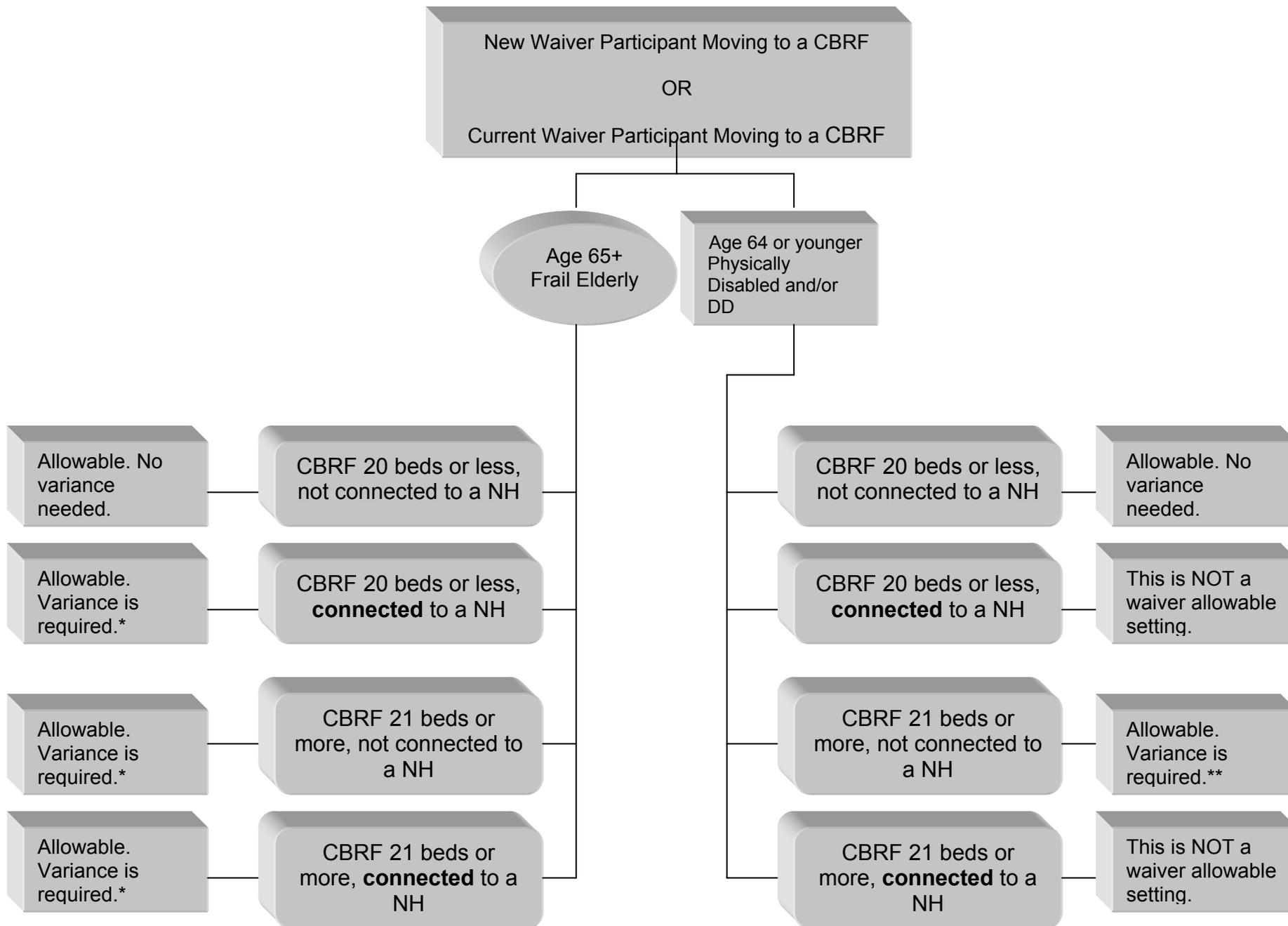
Example for PD individuals: *Rock County wishes to use Grandview CBRF- a 30 bed CBRF located within Rock County for a person who is age 55 and meets the target group definition of PD. The CBRF is not structurally connected to a nursing home. Rock County writes a variance with all the needed information and follows all appropriate protocols to get it approved internally. Rock County then submits the variance to the Department. Upon review, the Department grants Rock County a variance to use waiver funds in this specific 30 - bed CBRF. Later, Dane County would like to use this same 30 bed CBRF located in Rock County for a person who is age 59 and meets the definition of PD. Dane County must also write a variance with all the needed information and follow appropriate protocols to get it approved internally. Then, Dane County must submit the variance to the Department. Upon review, the Department will grant Dane County a variance to use waiver funds in this same 30 - bed CBRF.*

- In order to use waiver (or COP) funds in a CBRF (no matter the size), the 4 conditions/criteria for using waiver (or COP) funding must be applied and met for each individual.
- Participants are not eligible for State SSI-E if he/she resides in a CBRF that is 21 beds or more.

- Participants are not eligible for State SSI-E if he/she resides in a CBRF that is adjacent to, or part of, or on the grounds of an institution, even when a variance to received COP-W/CIP II funding has been approved.
- Medicaid does not fund personal care (MAPC) in CBRF's that have 21 beds or more.
- Prior to September 1, 2001, if an individual resided at a CBRF larger than 20 beds, and his/her services were being funded by COP and a variance request was already granted for that person in that specific facility, it is not necessary to request another variance just because the funding source has been changed to COP-W or CIP II.
- Important: a CBRF connected to a nursing home is **not** a waiver allowable setting for a person who is age 64 or under and meets the target group of PD, or PD and DD with no Mental Retardation.

For more information about using waiver funds for participants who reside permanently in CBRF's of 21 beds or more, please see DLTC Memo Series 2008-04 dated January 31, 2008. This memo supersedes DSL Memo Series 2002-25 – in part: (Sections regarding the COP, CIP II, COP-W CBRF variance processes.)

2008 CBRF Variance Requirements



* Person specific variance required. Complete and send ISP page 3B to TMG for all new applications and updates.

** Facility specific variance required. See Chapter Five of the Medicaid Waivers Manual. Send variance requests to BLTS for approval.

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 Care Manager/Support and Service Coordinator attests to the following:

1. The environment is non-institutional and the facility operates in a manner that 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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- 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, Participant, Authorized Representative

IMPORTANT NOTE ABOUT CHANGES THAT HAVE OCCURRED CONCERNING THE CRITERIA THAT HAS TO BE MET WHEN USING WAIVER FUNDS TO PAY FOR CARE RECEIVED IN A CBRF

As part of the 2007-2009 state budget bill, the requirement to have a pre-admission assessment/consultation has been repealed. Instead there are new notification requirements for CBRF operators, and a requirement that county/waiver agencies or ADRC's, as applicable, provide *option counseling* to prospective CBRF residents. County waiver agencies should document within the participant's file that options counseling was provided.

Briefly, options counseling involves giving information to the person or their representative regarding what options are available to meet the person's long term care needs and what factors a person should consider in making long-term care decisions. For a more detail description of options counseling please see Administrative Code HFS 10.23 (2) (c) and HFS 10.23 (2) (c) 1 through 5 at:

<http://nxt.legis.state.wi.us/nxt/gateway.dll?f=templates&fn=default.htm&vid=WI:Default&d=code&jd=top>

Please note while the **offer** of options counseling must always be met, the individual has a right to refuse options counseling. If that occurs, the county waiver agency should document within the file that options counseling was offered, but the individual or his/her representative declined.

However the remaining 4 criteria remain current. The following information gives insight and answers to commonly asked questions about the criteria.

Prior to residing in a CBRF of **any** size, four criteria need to be addressed and documented before waiver or COP funds can be utilized. .

The who, what, where, and why information about the four (4) criteria ...

Who is affected? Any person who wishes to receive COP or Waiver funds to assist with the cost of their service plan while residing in a CBRF.

What is it? Prior to utilizing COP or waiver funds to pay for the care and supervision at a CBRF, a county waiver agency has to consider four specific criteria. **Important note: the four criteria must be considered regardless of the size of the CBRF.** These criteria have been placed in Wisconsin statutes and must be adhered to by counties.

Where does this rule apply? *For all CBRF's. The four criteria must be considered no matter the bed capacity of the CBRF. FYI: in Wisconsin, the size of CBRFs range in bed capacity from five beds to over 200 bed capacity.

Why is this important? The purpose and primary focus of the COP and Waiver program is to provide funding to enable persons to remain in their own homes. The emphasis has always been on providing in-home care. When a person resides in a CBRF, it is felt the county waiver

agencies need to determine whether or not utilizing COP or waiver funds in a CBRF is consistent with the intent of the program.

When should the 4 criteria be applied? Prior to the person receiving funding to reside in the CBRF.

When did these criteria go into effect? The requirement to consider all 5 criteria when placing any new individual in a CBRF went into effect on September 1, 2002. However, the criteria to complete a pre-admission assessment or consultation has been eliminated as a result of a change made in the 2007-2009 state budget bill. However, with the changes that went into effect in October 2007 county waiver agencies will need to document that options counseling was offered and/or provided to the individual.

***Are there any situations where the 4 criteria do not have to be met?** Yes, there are 2 instances where the four criteria do not apply: 1) when a person resides or intends to reside in a CBRF that consists entirely of independent apartments (SPC 506.63), or, 2) to a person who has an irreversible dementia and who will be residing in a facility with a dementia care program. *A CBRF is considered to have a dementia care program when, at a minimum, the CBRF is designated as an Alzheimer's facility as determined by licensure and program statement, staff members receive client group specific training in dementia care, and staff members provide activity programming for persons with an irreversible dementia.*

The four criteria are:

- 1) The option of in-home services has been thoroughly explored and determined infeasible;
- 2) The CBRF is the person's preferred residence;
- 3) The CBRF provides a quality environment and quality care services;
- 4) The CBRF is cost-effective compared to other service options explored.

For more information on how these criteria need to be implemented/determined, please see DSL Memo series 2002-25 dated January 2, 2003 at http://dhfs.wisconsin.gov/dsl_info/NumberedMemos/DSL/CY_2002/NMemo2002-25.htm

Documenting the four criteria:

It must be documented within the participant's file that the 4 criteria have been applied for each waiver participant that resides in a CBRF.

The Bureau of Long Term Support (BLTS) has developed a model form that county waiver agencies can utilize that documents how the county waiver agency applied each of the criteria to the specific individual, and, the result of their efforts. This model form is available on BLTS's website at http://dhs.wisconsin.gov/LTC_COP/ModelForms/index.htm

NOTES:
