INDEPENDENT LIVING SUPPORTS PILOT (ILSP)
SERVICE PLAN

Completing and signing this form is voluntary; however, no referral to enroll in the ILSP Program can be processed without the completed signed form. To apply for this program, applicants must contact their local aging and disability resource center (ADRC). Contact information for local ADRCs can be found at www.dhs.wisconsin.gov/adrc/consumer/index.htm.

All information entered must be complete and accurate. The signature or signature of a legal guardian, conservator, or activated power of attorney for finance is required. If signing with a mark, two witness signatures are required. If physically unable to sign, the applicant may direct an adult to sign the form in front of two witnesses. The person who signs on the applicant's behalf should indicate that they are signing at the direction of the applicant.

Only Aging and Disability Resource Center (ADRC) staff is able to approve, finalize, or update the service plan. Information collected in this form will be provided to the ILSP third-party administrator to assist in provider onboarding and payment of claims.

Information will be shared with the Wisconsin Department of Health Services and its agents for ILSP administration and evaluation.

Service Plan

Name (Last, First, MI)			ILSP ID		Referring ADRC
Equipment/Service			Unit Type		Number of Units
Service Type		Code	Price (per unit) $		Total Cost $
Provider Name	Address		Phone Number		Background Check ☐ Yes ☐ No ☐ N/A
Email Address (if available)		Status ☐ New ☐ Updated ☐ Discontinued		End Date or ☐ As Soon as Possible	
Comments:					
Equipment/Service			Unit Type		Number of Units
Service Type		Code	Price (per unit) $		Total Cost $
Provider Name	Address		Phone Number		Background Check ☐ Yes ☐ No ☐ N/A
Email Address (if available)		Status ☐ New ☐ Updated ☐ Discontinued		End Date or ☐ As Soon as Possible	
Comments:					
Equipment/Service			Unit Type		Number of Units
Service Type		Code	Price (per unit) $		Total Cost $
Provider Name	Address		Phone Number		Background Check ☐ Yes ☐ No ☐ N/A
Email Address (if available)		Status ☐ New ☐ Updated ☐ Discontinued		End Date or ☐ As Soon as Possible	
Comments:					

Name (Last, First, MI)				ILSP ID	Referring ADRC
Equipment/Service				Unit Type	Number of Units
Service Type		Code		Price (per unit) $	Total Cost $
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Comments:					
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Equipment/Service				Unit Type	Number of Units
Service Type		Code		Price (per unit) $	Total Cost $
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Email Address (if available)		Status ☐ New ☐ Updated ☐ Discontinued		End Date or ☐ As Soon as Possible	
Comments:					

Authorization

Participant or legal representative is to initial below:

____ I understand that all service providers credentials must be verified by the third-party administrator prior to providing services. The third-party administrator will alert the provider and participant when approval is granted. Services may not be provided prior to this approval.

____ I understand that the service plan is an authorization to pay the provider after approval by the third-party administrator. Claims exceeding the approved amounts or maximum budget of $7,200 will not be authorized and will be the responsibility of the participant.

_____ I understand that my service plan is valid only while I am actively enrolled in the ILSP program. My enrollment will end 12 months from the date of enrollment on my application form.

_____ I understand that if I do not respond to calls from the ADRC and third-party administrator and do not use my services for three months, I will be disenrolled from the ILSP program.

SIGNATURE – Participant	Date Signed
SIGNATURE – Legal Guardian, Conservator, or Activated Power of Attorney for Finance	Date Signed
SIGNATURE – Legal Guardian, Conservator, or Activated Power of Attorney for Finance	Date Signed
SIGNATURE – Witness (if applicable)	Date Signed
SIGNATURE – Witness (if applicable)	Date Signed