INDEPENDENT LIVING SUPPORTS PILOT (ILSP) APPLICATION

Instructions and Important Information

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.

HOW TO USE THIS FORM

The ILSP Application form (F-03161) must accompany all referrals to enroll or in the ILSP program. All information must be complete and accurate. The participant's signature or the signature of a legal guardian, conservator, or activated power of attorney is required. If the applicant signs with a mark instead of a signature, two witness signatures are required. If the applicant is physically unable to sign, the applicant may direct another adult to sign the form in front of two witnesses. The person who signs on the applicant's behalf will indicate that they are signing at the direction of the applicant.

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

ADDITIONAL INSTRUCTIONS

Section I

- A **Social Security Number** is requested to facilitate fiscal agent processing of participant employer paperwork and for program evaluation data purposes.

Section II

- Per 8 U.S.C. 1621(a), only U.S. citizens, U.S. nationals, or certain documented immigrants may enroll in ILSP.
- A **certified or licensed facility** includes but is not limited to an adult family home (AFH), a community-based residential facility (CBRF), a skilled nursing facility, or a residential care apartment complex (RCAC).
- Living within the **ADRC's service area** is defined as residing in the county or counties to which the ADRC provides services. A person is considered to reside in a county if they are physically present in the county and living in a place of fixed habitation with an intent to remain voluntarily.
- **Long-term care Medicaid** programs include: Include, Respect, I Self-Direct (IRIS), Family Care, Family Care Partnership and Program of All-Inclusive Care for the Elderly (PACE).
    - Enrollment in a long-term care Medicaid program disqualifies applicants for ILSP.
    - Enrollment in Medicaid health insurance **does not** disqualify an applicant for ILSP.
- All applicants must provide a **primary diagnosis**. If an applicant is 55 or older and no primary diagnosis applies, the diagnosis of "Age 55+ with no primary diagnosis" may be entered.
    - To be eligible, a diagnosis must cause functional needs expected to last longer than 90 days from the date of the ILSP application.

  - Diagnoses in the Severe and Persistent Mental Illness (SPMI) category are not eligible as a primary diagnosis for ILSP.
  - Please consult the ILSP Diagnosis List for allowable diagnoses.
- **Additional diagnoses** are not required but may be helpful to add. Diagnoses in the SPMI target group are allowable in this category. If no additional diagnoses are expected to cause functional needs lasting longer than 90 days, N/A may be selected.
- All applicant **Income** should be included to reach a grand total. Applicants with a grand total income greater than 300% of the Federal Poverty Level are ineligible for the ILSP program. Spousal income and assets are not considered in application to the ILSP program.
- Applicants must answer “Yes” to at least one question in the **Functional Eligibility Screening Tool** to qualify for ILSP.
  - Answers of “Sometimes” should be marked as a “Yes.”
  - Even if an applicant has answered “Yes” to a question, all remaining questions in the tool must be answered prior to enrollment in the ILSP program.
- A **valid ID** includes a U.S. passport, state driver’s license or state identity card, school photo ID, employee photo ID, military dependent ID card, military ID or draft record, tribal records, such as a tribal ID card, a Certificate of Degree of Indian Blood, a tribal census document, or documents on tribal letterhead, or a United States Citizenship and Immigration Services (USCIS) photo ID.

Section III

- **Signature** of the application form is legal consent to participate in the ILSP program.

Section IV

- The ADRC will mark eligible applicant forms with an enrollment date that is the same as the date of signature.
- The ADRC will mark ineligible applicant forms with the reason for ineligibility.
- This section provides notice to ILSP applicants of the outcome of their application.

Section V

- ADRC worker will enter their information.

INDEPENDENT LIVING SUPPORTS PILOT: APPLICATION

I. REFERRAL INFORMATION

Demographics

Name (Last, First, MI)	Date of Birth	Referring ADRC
Address	City	Zip Code
Phone Number	Email Address	Best Time to Contact

Established Guardianship	Activated Power of Attorney	Name – Guardian/POA	
☐ Guardian of Person ☐ Guardian of Estate ☐ N/A	☐ Healthcare ☐ Finance ☐ N/A	Email Address	
		Phone Number	Best Time to Contact

Medical Insurance	Social Security Number
☐ Medicare ☐ Medicaid ☐ Private Insurance ☐ Uninsured	

Gender

☐ Female ☐ Male ☐ Transgender – Female
☐ Transgender – Male ☐ Other ☐ Prefer not to answer

Race/Ethnicity

☐ American Indian/Alaskan Native ☐ Asian
☐ Black or African American ☐ Hispanic Ethnicity
☐ Native Hawaiian or Other Pacific Islander ☐ White
☐ Other ☐ Prefer Not to Answer

What is your preferred language?	Language Interpreter Needed
	☐ N/A Language:

Name (Last, First, MI)	Date of Birth	Referring ADRC

Designated Contact Person

(Complete only if applicant requests another individual to be primary contact)

Designated Contact Person – Name	Relationship	Phone Number	Best time to contact

II. ELIGIBILITY INFORMATION

- ☐ I am a U.S. citizen or qualified immigrant per 8 U.S.C. 1621(a).
- ☐ I do not live in a certified or licensed facility.
- ☐ I live within this ADRC's service area.
- ☐ I am not currently enrolled in a long-term care (LTC) Medicaid program.
- ☐ Valid ID provided:

Primary Diagnosis:

Additional Diagnoses:

Name (Last, First, MI)	Date of Birth	Referring ADRC

Income

For each item below, enter your total gross (Before deductions) expected annual income for 12 months. (Do not include your spouse's income)

Gross Social Security	$
Gross Wages	$
Interest, Dividends, and Capital Gains	$
Net Self-Employment Income	$
Retirement Income	$
Other Income	$
Grand Total	$

Functional Eligibility Screening Tool

Do you have difficulty or need help performing any of these daily activities?		
1. Bathing The ability to shower, bathe or take a sponge bath for the purpose of maintaining adequate hygiene. Including Getting in and out of the tub or shower, turning on and off the faucet, and adjusting temperature to a safe temperature. Washing and drying the body. Shampooing hair.	Yes ☐	No ☐
2. Dressing Ability to safely dress and undress. This includes both the top and bottom of the body, undergarments, socks, and shoes. Putting on and removing prostheses, orthotic devices, anti-embolism hose (TED hose), compression products or devices, and/or pressure relieving devices. The cognitive ability to choose weather-appropriate clothing.	Yes ☐	No ☐

Name (Last, First, MI)	Date of Birth	Referring ADRC

3. Eating The act of getting food or drink from plate/bowl or cup to mouth (chewing if necessary and swallowing) using routine or adaptive utensils.	Yes ☐	No ☐
4. Mobility The ability to move between locations (including stairs) in the individual's living space. Living space is defined as kitchen, dining room, living room, bathroom, and sleeping area.	Yes ☐	No ☐
5. Toileting The ability to safely use the toilet, commode, bedpan, or urinal for bowel and/or bladder management in the home. Including locating the bathroom in your living space, transferring on and off the toilet, cleaning of the perineal area, changing of menstrual and/or incontinence products, or managing catheter or ostomy.	Yes ☐	No ☐
6. Transferring The ability to safely move between two surfaces. Including going from a sitting to a standing position and reverse.	Yes ☐	No ☐
7. Meal Preparation The ability to safely obtain and prepare simple meals, including the task of grocery shopping. Including opening food containers, safely using kitchen appliances, safely placing food in a dish and carrying it to a table, cutting food, proper food preparation and sanitation. Obtaining groceries including retrieving food at store, getting bags into a vehicle and home, and putting groceries away.	Yes ☐	No ☐

Name (Last, First, MI)	Date of Birth	Referring ADRC

8. Medication Administration: To take or be given a medication by any route (oral, topical, injectable etc.) except intravenously (IV) that is prescribed by a doctor and regularly taken. and/or Management: to set up or monitor a person's prescribed and regularly scheduled and used medications. This includes medication setup and medication monitoring.	Yes ☐	No ☐
9. Money Management The ability to handle money including paying bills and completing financial transactions for basic necessities (food, shelter, and clothing).	Yes ☐	No ☐
10. Household Chores Ability to complete one's personal laundry, routine housekeeping, and basic home maintenance tasks. This includes laundry, vacuuming, mopping, dishes, cleaning bathroom, wiping down surfaces, taking out the garbage, mowing the lawn, and snow removal.	Yes ☐	No ☐
11. Use of Telephone The physical and cognitive ability of a person to use a telephone or other device to exchange information with others, two-way communication.	Yes ☐	No ☐
12. Transportation The physical and cognitive ability to drive a regular or adaptive vehicle.	Yes ☐	No ☐

Name (Last, First, MI)	Date of Birth	Referring ADRC

III. AGREEMENT

I certify, under penalty of perjury and false swearing, that all my answers are correct and complete to the best of my knowledge, including information provided about citizenship or immigration status.

If I am found eligible, I consent to enrollment in the Independent Living Supports Pilot and to following all program rules found in the participant handbook.

I consent to sharing my information with the Wisconsin Department of Health Services and its agents for ILSP program administration and evaluation.

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

Name (Last, First, MI)	Date of Birth	Referring ADRC

IV. ELIGIBILITY FINDINGS (to be completed by ADRC)

☐ Applicant is Eligible for ILSP program Enrollment Date: _____

☐ Applicant is Ineligible for ILSP program due to the following reason(s):

- ☐ Financially ineligible
- ☐ Does not meet functional need
- ☐ Does not have a qualifying diagnosis
- ☐ Enrolled in a LTC Medicaid program
- ☐ Lives in a certified or licensed facility
- ☐ Does not live in ADRC's service area
- ☐ Does not meet citizenship requirements

V. INFORMATION COMPLETED BY

Name – ADRC Worker	Date
Phone Number	Email Address