DEPARTMENT OF HEALTH SERVICES **STATE OF WISCONSIN**
Division of Public Health
F-03162 (06/2024)

ILSP PROVIDER APPLICATION

INSTRUCTIONS
Completion of this form is an ILSP program requirement. Applicants will not be considered as ILSP program service providers until all necessary paperwork is completed, submitted, and verified.

Agency Provider is defined as entities whose employees furnish the service or from which goods are purchased.
Individual Provider is defined as a person who is in an independent practice and not employed by a provider agency.

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

PROVIDER DEMOGRAPHICS

Organization Name (if applicable)		Doing Business As (DBA): (if applicable)		
Provider's Name (Last, First, MI)	Phone Number	Email Address		
Address	City	State	ZIP Code	County

Are you applying as (choose one): ☐ Agency Provider ☐ Individual Provider

SERVICES TO BE PROVIDED: List the service(s) you wish to provide. Please reference the ILSP Service Definition Manual for a complete list of allowable services.

Services	**Does this service require a license or certification?**

LICENSING/CERTIFICATION: List all current licenses and certificates (if applicable). A copy of each is required with this application.

Title of Licensure/Certification	Type of Licensure/Certification	Licensure/Certification Number	State in which Licensure/Certification Obtained	Expiration Date

By signing below, I certify that background checks on all employees have been completed in accordance with the Wisconsin Caregiver Program.

If I am to provide specialized transportation, I certify that the vehicle used is and will be mechanically sound, has properly functioning lighting, safety, ventilation, and braking systems, and properly inflated tires without excessive wear. I further certify that proper licensing and insurance has been verified and is attached.

I understand and agree that this application will not be processed until it is deemed complete by DHS. It is my responsibility to provide a complete application. I understand and agree that the burden of producing adequate information in a timely manner and for resolving doubts is my responsibility.

I certify that the information in this document and all attached documents is true, correct, and complete. I understand and agree that any misrepresentation, misstatement, or omission from this application, if discovered after provider approval has been awarded, may lead to suspension or termination of provider approval.

SIGNATURE – Provider	Date Signed

Please submit this application to your Fiscal Agent (FA):

AGENCY	FAX	EMAIL	GROUND MAIL
Premier Financial Management Services	877-334-2584	ILSPHR@premier-fms.com	10425 W North Ave, Suite 312 Milwaukee, WI 53226