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.

Organization Name (If applicable)  Provider's Name (Last, First, MI)  Phone Number  Email Address  City  State  ZIP Code  County  Are you applying as (choose one):  SERVICES TO BE PROVIDED: List the service(s) you wish to provider. Please reference the ILSP Service Definition Manual for a complete list of allowable services.  Services  Does this service require a license or certification?  Licensure/Certification  Title of Licensure/Certification  Title of Licensure/Certification  Licensure/Certification  Licensure/Certification  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. 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.  Please submit this application to your Fiscal Agent (FA):  AGENCY FAX EMAIL GROUND MAIL  Management 877-334-2584  LISPHR@premier-fms.com  Number  Doing Business As (DBA): (Identified and saturated and agree that SPA): (Identified approval) and several and agree that SPA): (Identified approval) and several and agree that SPA (Identified approval) and several and several and agree that SPA (Identified approval)										
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