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| DEPARTMENT OF HEALTH SERVICESDivision of Medicaid ServicesF-20445 (09/2022)  |  | STATE OF WISCONSIN |

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| INDIVIDUAL SERVICE PLAN – children’s LONG-TERM SUPPORT programs |
| 1 Program(s)[ ]  CLTS Waiver Program [ ]  CCOP | 1a Plan Type[ ]  New [ ]  Recertification[ ]  Six-Month Review [ ]  Update | 2 **Initial** **ISP** Development Date      | 3 **Current ISP** Completion Date      | 4 MCI Number        |
| **PARTICIPANT INFORMATION** |
| 5 Participant’s Name      | 6 Address (street)      | 6a City, State, Zip Code      | 7 Date of Birth      |
| 8 Mailing Address (if different from street address)      | 9 Telephone      | 10 Email Address (optional)      | 11 Functional Screen Date      |
| **PROGRAM INFORMATION** |
| 12 Medicaid Cost Share (if any)      | 13 Estimated Parental Payment (if any)      | 14 Total Cost/Day       |
| 15 Current Living Arrangement (name or type)      |
| **AGENCY INFORMATION** |
| 16 Waiver Agency      | 16a Agency Telephone       | 17 Support and Service Coordinator (SSC)      | 17a SSC Telephone No./Ext.      |
| 16b Agency Mailing Address (street, city, state, Zip code)      | 17b SSC Mailing Address (if different from agency’s)      |
| 16c Agency Email Address (optional)      | 17c SSC Email Address      |
| **PARENT/GUARDIAN INFORMATION** |
| 18 Name – Parent(s) or Guardian      | 19 Email Address(es)      |
| 20 Mailing Address (if different from participant’s)      | 20a City, State, Zip Code      |
| 21 Telephone (cell)      | 21a Telephone (2nd cell, if applicable)      | 21b Telephone (home)       | 21c Telephone (work)       |
| **IN CASE OF EMERGENCY, NOTIFY:** |
| 22 Name      | 23 Telephone (preferred/primary)      | 24 Email Address      |
| 25 Address (street, city, state, Zip code)      | 26 Relationship      |

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**36** **Outlier Rate:** [ ]  Check this box when any service listed on this ISP uses a DHS-approved outlier rate.

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| **37 PARTICIPANT-INFORMED RIGHTS AND CHOICE** **Review Required at initial plan development and recertification. All lines apply to both CLTS Waiver and CCOP, unless otherwise indicated.**[ ]  I have been informed that I have a **right to CHOOSE** between institutional services and community services through a Medicaid Home and Community-Based Services (HCBS) Program (i.e., the CLTS Waiver Program). (This line does not apply to CCOP-only plans.)[ ]  I have been informed of my **CHOICES** through the children’s long-term support programs (i.e., the CLTS Waiver Program and/or CCOP), including my right to **CHOOSE the** **type of services** I receive under my service plan.[ ]  I understand that I have **CHOICES** through the children’s long-term support programs, including my right to **CHOOSE** from available, qualified providers who will provide the services outlined in my plan.[ ]  I have been informed verbally and in writing of my rights and responsibilities in the children’s long-term support programs, and I understand these rights and responsibilities.[ ]  I have been informed verbally and in writing of my **right to request a hearing** should I disagree with decisions made about my **ELIGIBILITY** to participate in the children’s long-term support programs. [ ]  I have been informed verbally and in writing of my **RIGHT TO REQUEST A HEARING** should I disagree with decisions made that would **DENY**, **reduce, or terminate** the services I receive.[ ]  I have chosen to accept community services through a Medicaid HCBS Waiver Program (i.e., the CLTS Waiver Program). (This line does not apply to CCOP-only plans.)**38 REVIEW/UPDATE VERIFICATION – ONLY APPLIES TO PLAN REVIEW OR ISP UPDATE**[ ]  The six-month ISP Review was completed with the participant and family on the date below and there are no changes to the ISP at this time.[ ]  The six-month ISP Review was completed with the participant and family on the date below and agreed-upon changes to the ISP are included herein.[ ]  The ISP was updated on the date below to reflect changes (additions, increases, or reductions) to planned services or providers or to units/frequency of service. |

**SIGNATURES: ISP signatures are required at the time of plan development, review, and recertification.**

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| **SIGNATURE** – Participant (if at least 14 years old) | Date Signed | **SIGNATURE** – Support and Service Coordinator | Date Signed |
| **SIGNATURE** – Parent/Guardian/Authorized Representative | Date Signed | **SIGNATURE** – Parent/Guardian/Authorized Representative | Date Signed |
| **SIGNATURE** – Witness (see instructions) | Date Signed |  |

**DISTRIBUTION:** Original – Support and Service Coordinator/Participant File; Copy – Participant/Parent/Guardian/Authorized Representative