DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-20445 (09/2022)

STATE OF WISCONSIN

INDIVIDUAL SERVICE PLAN – CHILDREN'S LONG-TERM SUPPORT PROGRAMS

1 Program(s)	1a Plan Type	2 **Initial ISP** Development Date	3 **Current ISP** Completion Date	4 MCI Number
☐ CLTS Waiver Program ☐ CCOP	☐ New ☐ Recertification ☐ Six-Month Review ☐ Update			

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

27 Service Code #	28 Service Name	28a Care Level (if applicable: low, medium, or high)	29 Outcome No. (F-20445A #5)	30 Service Provider Name, Address, Telephone No. (email, cell phone, if known)	31a Start Date	31b End Date	32 Unit Cost ($/hr or day)	33 Authorized Units and Frequency (#/day, week, or month)	34 Daily Cost (total yearly cost/ 365 days)	35 Funding Source

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

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.

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