

Jim Doyle
Governor

Karen E. Timberlake
Secretary



State of Wisconsin
Department of Health Services

DIVISION OF LONG TERM CARE

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Telephone: 608-266-2000
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TTY: 888-241-9432
dhs.wisconsin.gov

(Date)

(Case Manager Name and Address)

Re: Waiver Application for (Name)

Dear (case manager),

I have received and reviewed the CIP Waiver Application you submitted. According to Waiver Guidelines, there are a number of required elements that must be included in an application in order for it to be approved by our Bureau. Through the review process it is evident that the following information is missing or incomplete:

Assessment is lacking detail, with regard to: _____

ISP (BLTS 445) not complete, with regard to: _____

Paperwork / form missing

- Assessment ISP (BLTS 445) HSRS L1 screen (Must be printout, not hand written)
- Narrative CARES or Cost Share LTCFS

Additional requirements: _____

Expired form: _____

No guardian authorization – Individual Service Plan is not signed

Incomplete Form or Paperwork: _____

No cover letter from the county requesting and endorsing this application, or cover letter incomplete.

Other: _____

Please complete this information and send it to me at (CIS address) within seven days from your receipt of this letter. Following my receipt of these items, I will complete the application review process and be in contact with you regarding the approval of this application.

Sincerely,

(CIS)

PRO-ACT CLIENT CONTROL SHEET

1. Date:	2. Program: <input type="checkbox"/> CIP 1A <input type="checkbox"/> CIP 1B <input type="checkbox"/> BIW		
3. Last Name:	4. First Name:	5. MI:	6. Suffix:
7. Agency:	8. MA Number:	9. Date of Birth:	
10. County:	11. Support and Service Coordinator:	12. Phone #:	
13. Primary CIS: Secondary CIS:	14. Gender:	15. Ethnicity:	
16. Prior Living Arrangement (see code on back):			
17. Court Ordered? <input type="checkbox"/> Yes <input type="checkbox"/> No		18. Guardian Opposed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
19. START DATE: / /			
20. Characteristics (see code on back - give all that apply):			
21. Current Living Arrangement (see code on back):		22. Living With (See code on back):	
23. Address:			24. Phone:
25. Guardian is Self? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, relationship:			
26. Guardian:			27. Phone:
28. Address:			
29. City, State, Zip:			
30. Placement: <input type="checkbox"/> Relocated <input type="checkbox"/> Diverted <input type="checkbox"/> Replacement			
31. Slot Type:			
32. LOC:		33. Estimated Daily Rate:	
34. Variance? <input type="checkbox"/> Yes <input type="checkbox"/> No		35. Variance Type: Expiration Date:	
36. Other License? <input type="checkbox"/> Yes <input type="checkbox"/> No		37. Type (see back):	
38. Termination Date: / /		39. Service Termination Reason: (see code on back)	

CIP DATA CODES

CLIENT CHARACTERISTICS

- 02 Mental Illness (excluding SPMI)
- 06 Severe Communication Disorder
- 07 Blind/Visually Impaired
- 08 Hearing Impaired
- 09 Physically Disabled/Mobility Impaired
- 12 Alcohol & Other Drug Client
- 18 Alzheimer's Disease/Related Dementia
- 23 DD - Cerebral Palsy
- 25 DD - Autism
- 26 DD - Mental Retardation
- 27 DD - Epilepsy
- 28 DD - Other (See Case Notes)
- 29 DD - Prader-Willi
- 34 Brain Trauma - Injury Age < 21
- 35 Brain Trauma - Injury Age > 21
- 36 Other
- 37 Fragile Medical Condition
- 77 Challenging Behavior (not primary)
- 86 Severely Emotionally Disturbed
- 99 Unknown

PRIOR AND CURRENT¹ LIVING

- 06 State Mental Health Institute *
- 07 ICF/MR*
- 21 Adoptive Home
- 22 Foster Home - non-relative
- 23 Foster Home - relative
- 30 Own Home or Apartment
- 32 DD Center *
- 33 Nursing Home *
- 37 Adult Family Home (1-2 beds)
- 38 Adult Family Home (3-4 beds)
- 43 Group Home (child)*
- 50 BI Rehab Unit - Hospital*
- 51 BI Rehab Unit - Nursing Home*
- 61 CBRF 5-8 beds
- 62 CBRF over 8 beds *
- 70 Residential Care Apartment Complex
- 90 Transient
- 98 Other Living Arrangement
- 99 Unknown*

PEOPLE

- 05 Alone
- 09 Alone w/ paid supports
- 10 Family w/out paid supports
- 11 Family w/ paid supports
- 18 Others who do not use paid supports
- 19 Others who use paid supports

SLOT TYPE

- Closed Bed
- Local Match
- State Match
- Family Care
- ICF-MR

VARIANCE/Special Approval TYPE

- 01
- 04 Services on Grounds of Institution
- 05 Restrictive Measures
- 07 Alternative Case Management

OTHER LICENSE TYPE Not Licensed

- Licensed by State of WI
- Licensed or Certified by a County in WI
- Licensed by State of WI and County Certified
- Licensed by a Private Organization or another State
- Tribal

TERMINATION REASON

- 05 Moved Out Of State
- 06 Death of Client
- 11 No longer income eligible
- 14 No longer level of care eligible
- 32 Rejected service plan
- 35 Funding Switch to other public
- 38 Voluntarily terminated services
- 56 Unable to assure health, safety & welfare
- 65 Institutionalized, Behavioral
- 66 Institutionalized, Medical
- 67 Institutionalized, Loss of Care Giver
- 68 Institutionalized, Choice
- 69 Institutionalized Corrections/Jail
- 98 Other (See Case Notes)
- 99 Unknown

¹ Items with a * are not permitted as current living arrangements

CIP 1A/1B APPLICATION REVIEW CHECKLIST FOR CIS

1. Applicant Name:

2. County:

3. Date App. Received:

4. Date App. Approved:

5. Start Date of Services:

6. _____ Long Term Care Functional Screen Completed

1. _____ Date Completed _____ (Waiver start date can be + or - 90 days)
2. _____ DD level of care rating assigned (Circle one: DD1a, DD1b, DD2 or DD3).
3. _____ Result "Yes" to "Home and Community Based Waiver" Eligibility

7. _____ Individualized Service Plan Development Date (DSL 445): _____

1. _____ All services person is receiving are listed, including any non-waiver supports/services.
2. _____ Room and board costs (for regulated settings) and personal needs money listed on ISP.
3. _____ If there's a cost share with CARES, is reflected on the ISP and is being applied toward a waiver allowable service.
4. _____ Signed and dated by person and/or guardian
5. _____ "Service Plan Development Date" is prior or equal to service start date
6. _____ Outcomes documented on ISP
7. _____ Dental provider is listed on the ISP.
8. _____ Medical providers are listed on the ISP.
9. _____ All Providers are Qualified, as stated in the cover letter.

8. _____ Assessment includes:

1. _____ The assessment identifies informal and formal supports and/or services necessary to meet the applicant's needs. Including the applicant's preferences and lifestyle choices.
2. _____ Assessment information is current and accurate.
3. _____ Background and social history.
4. _____ Physical and medical health history.
5. _____ Individual outcomes important to the person.
6. _____ Ability to perform physical activities of daily living.
7. _____ Ability to perform instrumental activities of daily living.
8. _____ Emotional and cognitive function.
9. _____ Behaviors that positively or negatively affect lifestyle or relationships.
10. _____ Social participation, friendships, existing formal and informal social supports.
11. _____ Cultural, ethnic and spiritual influences.
12. _____ Community participation and involvement.
13. _____ Personal preferences as to how and where to live, preferred daily activities/routines and their environment.
14. _____ Risks associated with choices made in living arrangement, activities and relationships and behaviors.
15. _____ Economic resources available and how they are managed.
16. _____ Formal and informal supports available to the person.
17. _____ A discussion of participant rights and responsibilities including the individual's capability to understand and exercise them.
18. _____ A review of the applicant/participant's interest and ability to direct his/her own supports.

9. _____ Narrative Summary

1. _____ Includes description of the services listed on the ISP.
2. _____ Narrative Summary discusses/lists services at the time of application.
3. _____ Narrative Summary addresses specific forms of intervention needed by the person in the day, evening, and on the weekend.
4. _____ The narrative description identifies the physical, mental and/or emotional needs of the person,
5. _____ The narrative description identifies the services and formal and informal supports which will be provided or arranged to meet those needs.
6. _____ The narrative identifies the ways in which the person will utilize community resources and participate in community activities.
7. _____ The narrative identifies and explains the possibility for natural relationships.

8.	_____	The narrative provides a comprehensive view of the participant's history, current situation, and future plans.
9.	_____	Any Restrictive Measures are identified, applied for, and approved by the Department.
10.	_____	Cost Share or CARES: MA Eligibility Date: _____ *If Cost Share Worksheet (DSL 919): 1. _____ Completed appropriate sections. (Top of page, Section I, Section II, Section V) 2. _____ Person is an SSI Recipient (Group A) 3. _____ "MA Eligibility Date" on cost share is prior to or on the start date. *If CARES Form (If Group B or C, CARES form substitutes DSL 919): 1. _____ I.M./E.S. completed the form. 2. _____ If cost share determined, dollar amount is reflected on the ISP for MA waiver service. 3. _____ MA start date is prior to or on the Waiver start date. 4. _____ CARES reflects a "Pass" status on the screen 5. _____ OR if "Pending" status on the CARES screen, after county receipt of the waiver approval letter a "Pass" screen is completed by the county.
11.	_____	HSRS "Long Term Support Client Registration" Screen (L1) is printed out.
12.	_____	Cover letter from county agency submitting the plan, includes: 1. _____ County authorization of plan – county requesting review and approval of application 2. _____ County assurance that only qualified providers under the waiver are being utilized. 3. _____ Name of individual 4. _____ Type of slot requested 5. _____ Requested start date 6. _____ Request for variance <u>or</u> request to waive any requirement (if applicable) 7. _____ Service Coordinator start up hours (hours beyond 90 days, but less than 180 days, prior to the start date have CIS approval for submission to the waiver and are documented on the ISP
13.	_____	Service Coordinator hours prior to the start date: 1. _____ Hours addressing transition and placement planning up to 90 days prior to the start date are documented on the ISP. 2. _____ Hours beyond 90 days, but less than 180 days prior to the start date have CIS approval for submission to the waiver and are documented on ISP.
14.	_____	Variances Requested: _____ 1. _____ Services on the grounds of institution, include all information required. (i.e. Day Services)
15.	_____	Housing modifications documentation (All Ramp Requests and any other Housing Modification in excess of \$2,000) 1. _____ Written rationale and request for the housing modification. 2. _____ Modifications are listed on the ISP. 3. _____ Copy of the estimate for the modifications. 4. _____ A photograph, drawing, or copy of plan that illustrates the modifications.
16.	_____	Housing Start up – only applies for a person moving from an institution or from a home to establish an independent living arrangement 1. _____ Items purchased within 180 days of the individuals start date 2. _____ Items requested are allowable under service definition in Manual 3. _____ Written rationale for all items 4. _____ Start up is listed on the ISP
17.	_____	CIS Completing Form: _____ Date: _____

1. CIS NOTES ON APPLICATION REVIEW PROCESS:		
2. Date application received by CIS:	3. Date application approved by CIS:	
4. Applicant's Name:	5. County:	
6. Support and Service Coordinator:		
7. Form letter sent to Support and Service Coordinator:	8. <input type="checkbox"/> Yes <input type="checkbox"/> No	
	9. Date:	
10. <u>Additional Contacts:</u>		
11. Date:	12. Type of Contact: <input type="checkbox"/> Phone <input type="checkbox"/> e-mail <input type="checkbox"/> Written <input type="checkbox"/> face to face	13. Reason for Contact:
14. Comment:		
15. Date:	16. Type of Contact: <input type="checkbox"/> Phone <input type="checkbox"/> e-mail <input type="checkbox"/> Written <input type="checkbox"/> face to face	17. Reason for Contact:
18. Comment:		
19. Date:	20. Type of Contact: <input type="checkbox"/> Phone <input type="checkbox"/> e-mail <input type="checkbox"/> Written <input type="checkbox"/> face to face	21. Reason for Contact:
22. Comment:		
23. CODE NUMBERS FOR "REASON FOR CONTACT": 1. Assessment is lacking detail 2. ISP not complete 3. Paperwork / form missing		4. Expired form 5. No guardian authorization 6. Incomplete Form or Paperwork 7. Other
24. PLAN DENIED: <input type="checkbox"/> Yes <input type="checkbox"/> No		25. REASON (if yes):
26. Date Approval Letter sent to County:		27. **In order to approve this application, I had _____ contacts (telephone, e-mail, written, or face to face) with the county Support and Service Coordinator who is listed on the ISP.
28. CIS COMPLETING FORM:		29. Date: