**DEPARTMENT OF HEALTH SERVICES**

Division of Medicaid Services

F-20445 (3/2017)

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| INDIVIDUAL SERVICE PLAN – MEDICAID WAIVERS andComprehensive Community Services (CCS) Recovery plan | | | | | | | | | | | | | | | | | | | | | |
| 1 Waiver Program/Other Programs  CIP II  CIP II CRI.MFP  CIP II-DIV  COP-W  CIP 1A  CIP 1B  CLTS  CST  CCS  CCOP | | | | | 1a Plan Type  New  Recertification  Six Month Review  ISP Update | | | | | | | 1b **Current** ISP Date | | | | | | | 2 Medicaid ID or MCI Number (as applicable) | | |
|  | | | | |  | | | | | | |  | | | | | | |  | | |
| 3 Individual’s Name | | | 4 Address (street) | | | | | | | 4a City, State, Zip Code | | | | | | | | | 4b Date of Birth | | | |
|  | | |  | | | | | | |  | | | | | | | | |  | | | |
| 5 Mailing Address (If Different) | | | 6 Telephone | | | | 7 Email | | | | | | 8 **Initial** Service Plan Development Date | | | | | | 9 Functional Screen Date | | | |
|  | | |  | | | |  | | | | | |  | | | | | |  | | | |
| 10 Cost Share Amount | 11 Level of Care | | 12 Parental Fee (If Applicable) | | | | 13 Personal Discretionary Funds Available | | | 14 [Reserved] | | | | 15 Start Up/One-Time Cost -Total | | | | | 16 Waiver Cost/Day Total | | | |
|  |  | |  | | | |  | | |  | | | |  | | | | |  | | | |
| 17 Prior Living Arrangement-  HSRS Code (CLTS- N/A) | 18 Prior Living Arrangement-Name/Type | | | | | | 19 Current Living Arrangement-  HSRS Code (CLTS- N/A) | | | | 20 Current Living Arrangement-Name/Type | | | | | | | | | | | |
|  |  | | | | | |  | | | |  | | | | | | | | | | | |
| 21 Waiver Agency | | | 22 Agency Telephone No. | | | | | | 23 Support & Service Coordinator/Care Manager (SSC/CM) | | | | | | | | | 24 SSC/CM Telephone No./Ext. | | | | |
| Marquette County Human Services | | | 608-297-3124 | | | | | | Jodi Williams, CCS /Rebecca Hardell, CLTS | | | | | | | | | 297-3132 /297-3116 | | | | |
| 25 Mailing Address (Agency) | | City | | State | | Zip | | | 26 Mailing Address (SSC/CM) | | | | | | | | | | | | | |
| 428 Underwood Ave | | Montello | | WI | | 53949 | | |  | | | | | | | | | | | | | |
| 27 E-mail Address (Agency) | | | | | | | | | 28 E-mail Address (SSC/CM) | | | | | | | | | | | | | |
|  | | | | | | | | |  | | | | | | | | | | | | | |
| 29 Name – Parent(s) or Guardian | | | | | | | | | 30 Telephone No. (Home) | | | | | | 31 Telephone No. (Work) | | | | | | | |
|  | | | | | | | | |  | | | | | |  | | | | | | | |
| 32 Mailing Address (Street/PO Box) | | | | | | | | | 33 City | | | | | | | | 34 State | | | | 35 Zip | |
|  | | | | | | | | |  | | | | | | | |  | | | |  | |
| 36 E-mail Address | | | | | | | | | 37 Telephone No. (Cell) | | | | | | | | | | | | | |
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| **IN CASE OF EMERGENCY, NOTIFY:** | | | | | | | | |  | | | | | |  | | | | | | | |
| 38 Name | | | | | | | | | 39 Telephone (Preferred/Primary No.) | | | | | | 40 Email Address | | | | | | | |
|  | | | | | | | | |  | | | | | |  | | | | | | | |
| 41 Address | | | | | | | | 42 City | | | | | 43 State | | | 44 Zip | | | | 45 Relationship | | |
|  | | | | | | | |  | | | | |  | | |  | | | |  | | |

**COMPLETE FOR CCS**

**Date of Service Plan Completion:** Date of Completion

If not within 30 days of application, provide specific reason: If applicable, enter reason

**Service Facilitator:** Service Facilitator **Dates of Service Plan Review:** Dates of Plan Review

(at least every six months or as consumer’s situation changes)

**Date the Service Planning Process was Explained to the Consumer and/or legal representative or family member:** Date process explained

**Consumer strengths:**

Enter consumer strengths

**Consumer barriers:**

Enter barriers

**Discharge from the CCS shall be based on one of the following:**

* The consumer has met / is meeting their recovery goals
* The consumer no longer wants psychosocial rehabilitation services
* DHS 36.17(5)(a)2.The whereabouts of the consumer are unknown for at least 3 months despite diligent efforts to locate the consumer
* [Down](http://docs.legis.wisconsin.gov/scroll/down/452/code/admin_code/dhs/030/36)
* [Up](http://docs.legis.wisconsin.gov/scroll/up/453/code/admin_code/dhs/030/36)
* DHS 36.17(5)(a)3.The consumer refuses services from the CCS for at least 3 months despite diligent outreach efforts to engage the consumer
* DHS 36.17(5)(a)4.The consumer enters a long-term care facility for medical reasons and is unlikely to return to community living
* DHS 36.17(5)(a)5.DHS 36.17(5)(a)6.Psychosocial rehabilitation services are no longer needed

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| **INDIVIDUAL SERVICE PLAN – INDIVIDUAL OUTCOMES** | | | |
| 1. Waiver Program:  CLTS Waiver (Indicate Target Group):  DD  MH  PD  CCS  CIP 1A  CIP 1B  BIW  CIP II  COP-W  COR  CCOP | | 2. Name - Support and Service Coordinator/Care Manager, Agency  Jodi Williams CCS  Rebecca Hardell CLTS | |
| 3. Name - Applicant/Participant | | 4. Medicaid ID Number | |
| 5. Outcome  Number | 6. Desired Outcome(s) Addressed in Service Plan | 7. Outcome Status or Progress Update | 8. Date |

**DEPARTMENT OF HEALTH SERVICES**

Division of Medicaid Services

F-20445A (3/2017)

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| 62  Service Code # | 63  Service Name\* | 64  Outcome No. (F-20445A #5) | 65  Service Provider Name Address and Telephone No.  (Email, cell phone no., if known) | 65a  Start Date | 65b  End Date | 66  Unit Cost ($/hr; day) | 67  Authorized Units of Service and Frequency (#/day or week or month) | 68  Daily Cost (total yearly ÷ 365 days) | 69  Funding Source | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| SPC 510.10  SPC 604 | | CCS Service Facilitation  Support and Service Coordinator | 1  1,2, 3 | Jodi Williams, MCCS  480 Underwood Ave., Montello, WI 53949  phone: 608-297-3132 email:jwilliams@co.marquette.wi.us  Rebecca Hardell, MCDHS  428 Underwood Ave., Montello, WI 53949  Phone: 608-297-3116  Email:rhardell@co.marquette.wi.us | 1/31/18 | 12/31/18 | $91.41/hr  $84.24/hr | 4 hours/month  2.5 hours/month | $12.02  $6.92 | MA  CLTS Waiver |
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\* 63. Service Name: For CCS, list one of the following Service Categories: Screening and Assessment, Service Planning, Service Facilitation, Diagnostic Evaluations, Medication Management, Physical Health Monitoring, Peer Support, Individual Skill Development and Enhancement, Employment-Related Skill Training, Individual and/or Family Psychoeducation, Wellness Management and Recovery/Recovery Report Services, Psychotherapy, Substance Abuse Treatment, Non-Traditional or Other Approved Services, or Other

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| **70 PARTICIPANT INFORMED – RIGHTS AND CHOICE (Review Required at initial plan development and recertification.)**  I have been informed that I have a **right to CHOOSE** between a nursing home or ICF-IDD and community services through a Medicaid Home and Community Based Service Program.  I have been informed of my **CHOICES** in the waiver programs, including my right to **CHOOSE the** **type of services** I receive under my service plan.  I understand that I have CHOICES in the waiver programs, including my right to CHOOSE from available, qualified providers that will provide the services outlined in my plan.  I have been informed verbally and in writing of my rights and responsibilities in the Medicaid Waiver 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 HCBS program.  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.  By **my signature** below I indicate I have chosen to accept community services through a Medicaid Home and Community Waiver Program.  **71 UPDATE/REVIEW VERIFICATION - APPLIES TO PLAN REVIEW OR ISP UPDATE ONLY**  The SIX MONTH ISP Review was completed with the participant/guardian 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/guardian 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 Signature Requirements apply at the time of plan development, review and recertification.** | | | |
| **SIGNATURE** - Participant | Date Signed | **SIGNATURE –** Support and Service Coordinator/Care Manager | Date Signed |
| **SIGNATURE** – Guardian/Authorized Representative/Parent | Date Signed | **SIGNATURE -** Guardian/Authorized Representative/Parent | Date Signed |
| **SIGNATURE** - Witness | Date Signed | **SIGNATURE –** Witness | Date Signed |
| **SIGNATURE** – Team Member | Date Signed | **SIGNATURE –** Team Member | Date Signed |
| **DISTRIBUTION:** Original – DHS; Copy - County Care Manager/Support and Service Coordinator; Copy – Individual; Copy - Authorized Representative | | | |

**Comprehensive Community Services Signature Page** Date of Plan:

I have been explained the service planning process by the service facilitator and/or mental health professional. I understand my options within the CCS Service Array. I have participated in the service planning process.

I am signing off on the plan as \_\_\_ Initial \_\_\_\_ Update \_\_\_\_ Final

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Consumer Dated

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Guardian Dated

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Service Facilitator Dated

I have reviewed and attest to this applicant’s need for psychosocial services as set forth in DHS 36 and medical and supportive services to address the desired recovery goals. I am authorizing services per the plan.

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Substance Abuse Professional Dated

I have reviewed and attest to this applicant’s need for psychosocial services as set forth in DHS 36 and medical and supportive services to address the desired recovery goals. I am authorizing services per the plan.

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Mental Health Professional Dated

**CCS Service Planning Meeting Roster**

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| --- | --- | --- | --- | --- |
| **Date** | **Name of Attendee/Relationship** | **Signature** | **Address** | **Telephone Number** |
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| **DEPARTMENT OF HEALTH SERVICES** **STATE OF WISCONSIN**  Division of Medicaid Services  F-20445A (03/2017) |

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| INSTRUCTIONS – INDIVIDUAL SERVICE PLAN – INDIVIDUAL OUTCOMES | | |
|  | | |
| No. | Title | Description |
| 1 | Waiver Program | Indicate the waiver program serving the applicant/participant |
| 2 | Support and Service Coordinator/Care Manager, Agency | Enter the Support and Service Coordinator/Care Manager and Agency Name |
| 3 | Participant Name | Enter the full legal name: last name, first name, middle initial and any suffix (e.g., Jr.) |
| 4 | Medicaid ID Number | Enter the ten digit Medicaid Number |
| 5 | Outcome Number | Assign a number corresponding to each individual outcome listed. The outcomes should be listed in order of their priority (as designated by the applicant/participant) |
| 6 | Desired Outcome(s) Addressed in Service Plan | Describe the individual outcome identified by the applicant/participant. Each SPC code or paid/unpaid informal support listed on the 445 should support the pursuit of an individual outcome.  For CCS, the desired outcomes should be transferred as stated on the Assessment Summary. Goal should be stated in the individual’s own words, and include statement of dreams, hopes, role functions and visions of life. |
| 7 | Outcome Status or Progress Update | Note any progress or update status of the individual outcome. Note ‘new’ if this is a new outcome being added. Indicate person(s)/agency responsible or who have a role in the attainment of the outcome.  For CCS, include how the objective was met or partially met; barriers to meeting the objective; consumer and team discussion, and consumer satisfaction with services. |
| 8 | Date | Enter the date the outcome was developed, updated or achieved, as applicable. |