INDIVIDUAL SERVICE PLAN SIGNATURE PAGE FOR:

Administering County Agency: DANE COUNTY DEVELOPMENTAL DISABILITY UNIT - ADULT PROGRAMS (CIP)
1202 Northport Drive, Madison, WI 53704 Telephone: (608) 242-6200

Are there services/providers included in this ISP that have conflicts of interest or potential conflicts of interest?
____ **NO** ____ **YES** If yes, complete Conflict of Interest Plan of Action, found in the Broker Manual.

- I have been given a copy of Dane County's policy regarding confidential information including protected medical information and the acknowledgement regarding Specialized Transit Services.
- 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 program, 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.
- I understand that I am allowed by MA Waiver regulations to voluntarily use my SSI and/or SSI-E for my supervision and services if those services are not allowable by the MA Waiver, or the total cost of Waiver services are beyond the county-contracted average level. If this is the case, I am willing to use my SSI and/or SSI-E for my supervision and services.
- By my signature below I indicate I have chosen to **accept** community services through a Medicaid Home and Community Waiver Program.

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, reductions) to planned services or providers or to units/frequency of service.

Signature - Participant:	**Date:**	**Signature -** Guardian/Authorized Representative:	**Date:**
Signature - Support and Service Coordinator/Care Manager:	**Date:**	**Signature -** Witness (Identify):	**Date:**
Signature - Witness (Identify):	**Date:**		

DISTRIBUTION: Original – DHS; Copy – County Care Manager/Support Service Coordinator; Copy – Individual; Copy – Authorized Representative