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| **DEPARTMENT OF HEALTH SERVICES**  Division of Medicaid Services  F-01205J (02/2017) | | **STATE OF WISCONSIN** | |
| **IRIS PARTICIPANT EDUCATION: SELF-DIRECTED PERSONAL CARE** | | | |
| **INSTRUCTIONS:** | This form is to be used as acknowledgement of compliance with IRIS program participant education. Completion of this form is not required through Wisconsin State Statute; however, completion of this form is an IRIS SDPC program requirement. The IRIS SDPC Nurse must also acknowledge the review of this form. | | |
| **NOTE:** | **All paperwork must be maintained in the participant’s record and must be available for review upon request by DHS.** | | |
| 1. I have discussed my preferences in the development of My Cares with the SDPC Nurse and I agree with the identified areas of care needed. I understand I will receive a new My Cares every year or sooner if the RN reassesses my needs. | | | |
| 1. I understand that if I am currently billing a Medical Assistance Personal Care agency for personal cares (MAPC), I must stop billing on the day before this care plan goes into effect. I may not seek services from another personal care agency while receiving Self-Directed Personal Care funding. | | | |
| 1. I understand that I must notify my SDPC Nurse if I become eligible to receive any other Home Health Service such as **Hospice, Home Health** or **Private Duty Nursing** services. I understand that if I need skilled nursing care and have Medicare I may not bill for both SDPC services and Home Health/Skilled Nursing care at the same time. My SDPC services will be put on hold until I notify my SDPC Nurse of the end date for my Home Health/Skilled Nursing care services (Medicare). | | | |
| 1. In order to receive SDPC, I agree to Oversight Visits as agreed upon in this care plan. If these visits are not completed, SDPC services will be put on hold or services may be discontinued. SDPC Nurses must visit me every 60 days or on a schedule agreed upon by me, my SDPC Nurse and physician. The SDPC Nurse can increase the frequency of visits as needed to ensure the provision of a safe plan. If a variance to this schedule is requested:  * I will notify my SDPC Nurse of any change in condition that may impact personal care needs. * My SDPC Nurse may need to call me every 60 days to ensure that My Cares Instruction Sheet is up to date and accurate. | | | |
| 1. I will notify my SDPC Nurse if I have a change in address or phone number. | | | |
| 1. I understand that SDPC is non-billable for out-of-state care unless I gain approval from my nurse for an extended period of time such as for traveling for work (one month notice). However, if the approved travel interferes with my assessments, oversight visits, etc. I may have a lapse in services. If I will be out of the State of Wisconsin I must notify my nurse. SDPC is a State of Wisconsin Medicaid Card service and is not billable out of the USA. | | | |
| 1. I must notify my SDPC Nurse within 24 hours of a hospitalization, nursing home admission, incarceration or admission to another Long Term Care facility. I understand that my SDPC workers may not bill for services while I am in the hospital or another institution. | | | |
| 1. I am aware that my SDPC allocation will not increase for the short-term help I may need after surgery or due to temporary illness or injury. I understand that my PRN hours (as needed hours) are built into this plan to cover periods of increased care needs. | | | |
| 1. I may only bill for the hours authorized by the SDPC RN and can’t bill over the authorized amount. I understand the SDPC hours do not carry over from week to week. Per DHS policy, my SDPC workers may not work over 40 hours per week (for all IRIS services combined). I am responsible to ensure my care givers work and bill the correct amount. | | | |
| 1. I will be given a weekly allocation of hours; if I choose to use my hours daily, I must divide these hours by the number of days in a week (7). I can also vary my hours day to day as long as I do not exceed my weekly allocation. | | | |
| 1. I am responsible for hiring, training and supervising my staff. I will train my workers on the cares listed in mycare plan as well as on standard precautions such as hand-washing and glove use. If I need additional support in training my workers, I will consult my SDPC Nurse. | | | |
| 1. In the event of a long term change in my condition that is likely to affect My Cares instructions due to an increase or decrease in my personal care needs, and my SDPC Nurse determines that I have had a long term change in condition, my plan will be reviewed and the expiration date and authorized hours may change. | | | |
| 1. If I have an SDPC Representative, they may not bill for the provision of personal cares. If this representative changes, I will contact my SDPC RN. | | | |
| 1. I understand I can be involuntarily disenrolled from Self-Directed Personal Cares when:  * My health and safety is jeopardized. * My purchasing authority is mismanaged. For example, this includes but is not limited to possible fraud, misrepresentation, inadvertent or mistaken reporting. * I move to an ineligible living arrangement. * I no longer meet the eligibility criteria for IRIS SDPC. | | | |
| **Please ensure completion of signature page.** | | | |
| My signature below indicates that my IRIS SDPC Nurse has reviewed this entire document with me and I have had the opportunity to have all of my questions asked. My signature also indicates that I understand the material above as presented to me. I further acknowledge that falsifying my Personal Cares Tool is considered to be fraud under Wisconsin State Statute § 49.49 and is punishable by up to 6 years in prison and/or $10,000 per incident.  I understand that if I have questions regarding my responsibilities as a participant in the IRIS SDPC program in the future, that I may address them with my IRIS SDPC Nurse. My signature also indicates that I understand that if I do not follow IRIS policies, I could be asked to leave the IRIS program. | | | |
| **SIGNATURE** – Participant | | | Date Signed |
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| **SIGNATURE** – Guardian (If applicable) | | | Date Signed |
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| My signature below indicates that I personally reviewed this document with the participant and/or guardian and provided them with the opportunity to ask questions. | | | |
| **SIGNATURE** – IRIS SDPC Nurse | | | Date Signed |
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| Please check one of the following: | | | |
| Initial Orientation | | | |
| Annual Visit | | | |
| Record Review Remediation | | | |