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| **DEPARTMENT OF HEALTH SERVICES**Division of Medicaid ServicesF-01566 (02/2020) | **STATE OF WISCONSIN** |
| **IRIS SELF-DIRECTED PERSONAL CARE (SDPC) – MY CARES** |
| **INSTRUCTIONS:** | Completion of this form is not required through Wisconsin State Statute; however, completion of this form is an IRIS program requirement per IRIS Policy Manual Chapter 13 – ‘IRIS Self-Directed Personal Care (SDPC). |
| **SECTION I: DEMOGRAPHICS** |
| Participant’s Name (Last, First)      | Date of Birth      | Telephone Number      |
| Guardianship:[ ]  Full [ ]  Of Person [ ]  Not Applicable | Health Care Power of Attorney (HCPOA) [ ]  Active [ ]  Inactive [ ]  Not Applicable |
| Supported Decision Maker      | Telephone Number      |
| Guardian/HCPOA (Last, First) (if applicable)      | Telephone Number      |
| Emergency Contact (Last, First)      | Telephone Number      |
| SDPC Representative (Last, First)      | Telephone Number      |
| Health Coverage:[ ]  Medicare [ ]  Medicaid [ ]  Private Insurance |
| This individual participates in activities outside the home.[ ]  Yes [ ]  No | Type (work, school, etc./)       | Frequency (hours per day/wk.)      |
| Living Situation (check all that apply): |
| [ ]  Own Home or Apartment[ ]  Alone[ ]  With Spouse/Partner/Family[ ]  Someone Else’s Home[ ]  Paid Live-In Caretaker[ ]  With Non-Relative Roommate | [ ]  Non-Relative 1-2 AFH\*[ ]  Caregiver’s Home[ ]  Support Services Provider[ ]  Apartment with Services\*[ ]  Group Residential/AFH 3-4 Bed\*[ ]  Institution/Facility\* |
| \*Participants residing in one of these settings are ineligible for SDPC unless the residence is owned by a person related by blood or marriage. |
| **SECTION II: MY PLAN OF CARE** |
| My desired outcomes      |
| My personal strengths      |
| My personal care schedule: |
| I was assessed and authorized **up to and not to exceed**       hours of personal care **per week**. I will ensure my workers will not bill for any hours over what is approved per week, and I understand that hours will not carry over. **I understand that billing over the hours that the physician and RN authorize may lead to disenrollment from SDPC.**I further understand that my plan is valid for one year. If there is a change in my condition I must notify my nurse. |

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| **SECTION III: MY CARE INSTRUCTIONS:** |
| **BATHING:** Includes preventative skin care, dressing and transfers. | **Care Need:**Choose one. | **Frequency:**Choose one. |
| **My preferences for Bathing:**      |
| **DRESSING:** The ability to dress and undress. | **Upper Body Need:**Choose one. | **Frequency:**Choose one. |
| **Lower Body Need:**Choose one. | **Frequency:**Choose one. |
| **My preferences for Dressing (RN to include any prescription stockings, orthotics, or prosthetics):** |
| **GROOMING:** Includes hair care, oral hygiene, shaving and nail care. | **Care Need:**Choose one. | **Frequency:**Choose one. |
| **My preferences for Grooming:**      |
| **EATING:**  Includes eating assistance/feeding; does not include meal preparation or setup. | **Care Need:**Choose one. | **Frequency****Breakfast:** Choose one.**Lunch:** Choose one.**Dinner:** Choose one. |
| **My preference for Cares:**      |
| **MOBILITY AT HOME:** Includes physical assistance and assistive devices. | **Care Need:**Choose one. | **Frequency:**Choose one. |
| **My preference for Eating:**      |
| **TOILETING:** Includes incontinence care and transfers. | **Care Need 1:**Choose one. | **Frequency:**Choose one. |
| **Care Need 2:**Choose one. | **Frequency:**Choose one. |
| **My preference for Toileting:**      |
| **TRANSFERRING:** Does not include transfers related to bathing or toileting. | **Care Need:**Choose one. | **Frequency:**Choose one. |
| **My preference for Transferring:**      |

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| **MEDICALLY ORIENTED TASKS MAY INCLUDE THE FOLLOWING:****[ ]** Medication Assistance[ ]  Glucometer Readings[ ]  Prescription Skin Care[ ]  Suprapubic Catheter Site Care[ ]  G/J Tube Site Care[ ]  Complex Positioning[ ]  Continuous Tube Feed[ ]  Intermittent Tube Feeding[ ]  Tracheostomy Care[ ]  Oral Suctioning[ ]  Chest Physiotherapy[ ]  Nebulizer Setup[ ]  Bowel Program[ ]  Range of Motion Exercises[ ]  Other Medical Tasks | **Care Need:**      | **Frequency:**      |
| **My preference for Medically Oriented Tasks:**      |
| **INCIDENTAL SERVICES:** May include changing sheets, laundering bed linens and clothing, care of eyeglasses and hearing aids, light cleaning in essential areas of the home, purchasing food, preparing meals and cleaning dishes. |
| **Care Need:**Choose one. |
| **My preference for Cares:**      |
| **SAFETY PRECAUTIONS:** May include seizure plan of care, behavioral interventions, safety with transfers and mobility, etc. |
|       |
| **My preference for Safety Cares:**      |
| **OTHER CARES AND CONSIDERATIONS**Choose one. |
| **Additional Precautions/Preferences:**      |
|  **Backup Plan for Personal Care:**Listed are individuals who may assist me with my essential personal cares when my caregiver(s) are unavailable for a shift. This plan is to ensure the cares that I cannot go a shift/day without, such as feeding, respiratory care, complex positioning, assistance with medications, toileting, or bowel program are completed.

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| **Name of Person** | **Phone** | **Cares to Complete** |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |

RN to ensure this is a safe back up plan and that there is a person (s) listed to complete essential cares when there is not a PHW available.  |
| IRIS Self-Directed Person Care Nurses must visit a person **every 60 days** unless an alternative visit schedule is authorized. For this participant, the oversight schedule will be: Choose one. |
| **INTER-OFFICE USE ONLY:** | [ ]  001 [ ]  002 [ ]  003 |
| **NAME** – Authorizing SDPC Registered Nurse | **Date Authorized to Begin Plan** |
|       | Click or tap to enter a date.**Plan Valid Through Certification End Date**Click or tap to enter a date. |
| To contact your nurse, call the IRIS SDPC Oversight Agency toll-free at 1-844-747-7372 |