|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **DEPARTMENT OF HEALTH SERVICES**  Division of Medicaid Services  F-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. | | | | |

|  |  |  |
| --- | --- | --- |
| **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:** | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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.   |  |  |  | | --- | --- | --- | | **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 | | | | |