

PERSONAL CARE AGENCY CLIENT CONSENT TO HOME VISIT

CLIENT INFORMATION

Name – Client

Address

City

State

Zip Code

CLIENT CONSENT TO HOME VISIT

By this document, I hereby consent to have State of Wisconsin survey personnel conduct a home visit to ensure that the State requirements for the provision of personal care are met and to assist in evaluating the effectiveness and quality of personal care services that I receive from:

Name – Personal Care Agency

Location - City

CLIENT ATTESTATION TO CLIENT RIGHTS

I understand that consent for this visit is voluntary and that none of my rights to confidentiality or privacy are waived by my consent. I have been told and I understand that refusal to consent to a home visit will have no effect on the level or nature of Medicaid benefits to which I am entitled.

SIGNATURE - Client or Legal Representative of Client

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Date Signed

SIGNATURE – Surveyor

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Date Signed