

PERSONAL CARE AGENCY CLIENT CONSENT FOR HOME VISIT

Name – Client			
Address	City	State	Zip Code

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	Approval Number

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 Patient ➤	Date Signed
SIGNATURE – Surveyor ➤	Date Signed