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| **DEPARTMENT OF HEALTH SERVICES**Division of Medicaid ServicesF-01201C (02/2017) | **STATE OF WISCONSIN** |
| **IRIS PARTICIPANT EMPLOYER / PARTICIPANT- HIRED WORKER AGREEMENT** |
| **INSTRUCTIONS:** | Completion of this form is not required through Wisconsin State Statute; however, completion of this form is an IRIS Program requirement. Both the participant-hired worker and the participant employer must sign and date the bottom in order to be considered complete. Participant-hired worker may not begin working for participant employer until they have received a mailed start date letter.Personally identifiable information on this form is collected to verify that the application is complete, and will be used only for this purpose.Completed forms should be submitted to the participant’s Fiscal Employer Agent. |
| Name – Participant-Hired Worker (Last, First)      | Name – Participant Employer (Last, First)      |
| Date of Birth – Participant-Hired Worker      |
| The participant employer requires the following tasks and duties to be performed by the participant-hired worker:      |
| The participant employer agrees to provide/arrange for worker training as described below:      |
| **Participant-Hired Worker Schedule – Indicate Day(s) of the Week Participant-Hired Worker Will Provide Service(s)** |
| **Service** | **Sunday** | **Monday** | **Tuesday** | **Wednesday** | **Thursday** | **Friday** | **Saturday** |
| Supportive Home Care (SHC) | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Self-Directed Personal Care (SDPC) | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Respite Care (R) | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Other | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Mileage | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| If “Other”, please explain:       |
| **Participant-Hired Worker Services – Indicate Which Service(s), Pay Rate(s), Unit Type(s) and Units Per Week the Participant-Hired Worker will Provide** |
| **Service** | **Pay Rate** | **Unit Type (per hour, per day, etc.)** | **Units/Week** |
| Supportive Home Care (SHC) |  |  |  |
| Self-Directed Personal Care (SDPC) |  |  |  |
| Respite Care (R) |  |  |  |
| Other |  |  |  |
| Mileage | Indicate the rate and the number of miles per month the participant-hired worker is authorized to provide. |
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| If “Other”, please explain:       |

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| **BY SIGNING BELOW:** |
| I (We) understand that the services are provided under Medicaid regulations and that I (we) may not charge in excess of the amount authorized on the participant employer’s plan. After the participant-hired worker has performed the service(s) per this agreement, time reports are due to the participant’s Fiscal Employer Agent. |
| Both signers agree to only submit time reports within the hours authorized. Without prior approval, excess hours claimed above the authorization may be rejected for payment. |
| **SIGNATURE** – Participant-Hired Worker | Date Signed |
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| **SIGNATURE** – Participant Employer | Date Signed |
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