

PARTICIPATION AGREEMENT – EDUCATION SERVICES

FOR AGENCY USE ONLY

Client ID No.

Case ID No.

The Wisconsin Asthma-Safe Homes Program provides asthma education and an environmental check of your home. The program may help you manage your (or your child's) asthma. We need your (or a legal guardian's) consent to provide education services (home visits) and share information with the agencies and providers listed below.

Consent to receive education services

If you agree to receive education services, your asthma educator will contact you to schedule a minimum of two and a maximum of six home visits, a 2-week follow-up phone call, and a 3-month follow-up visit. The benefits you will receive are free asthma management education and resources from a trained asthma educator, recommendations about your home environment and supplies to reduce asthma triggers.

Through your participation, there is a possibility that you will be referred to the Asthma-Safe Homes Program's environmental services. Environmental services could include home fixes to reduce asthma triggers if the home qualifies. You can decline services at any time. We ask that you communicate with your asthma educator if you no longer wish to participate in the program, your contact information changes, or your need to reschedule an appointment.

Consent to release information

Your asthma educator shares information learned during the home visits with the Asthma-Safe Homes Program administrators at the Wisconsin Department of Health Services for purposes of reporting and program improvement. Any information shared for those purposes will not include identifiable information.

Additionally, with your consent your asthma educator will share information from the visit with your (or your child's) primary care or other qualified health care provider. This may include a summary of the asthma control assessment and recommendations provided by your asthma educator during the home visits and follow-up. The benefit of sharing this information with a health care provider is that it may improve the care you (or your child) receive to improve asthma control and decrease asthma symptoms.

Please read and sign the following:

I understand the information presented through the Asthma-Safe Homes Program is for the purpose of education about asthma and does not take the place of a visit, call, or the advice of my personal physician or other qualified health care provider. I understand that if I have any health care related questions, I should call and/or see my physician or other qualified health care provider promptly.

By signing below, I give my permission to the Asthma-Safe Homes Program to:

1. Complete the first home visit on _____ (mm/dd/yyyy)
2. Share information learned with the following agencies and providers:

Name – Primary Care Provider	Name – Specialist
Address	Address
Telephone No. (include area code)	Telephone No. (include area code)

I decline to share information with health care provider(s)

PRINT – Self/Parent/Guardian	SIGNATURE – Self/Parent/Guardian	Date
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DISTRIBUTION: Client or Parent/Guardian
Asthma-Safe Homes Program
Health Care Provider(s) (if permission given)