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| **DEPARTMENT OF HEALTH SERVICES**  Division of Public Health  F-02210 (09/2017) | | | **STATE OF WISCONSIN** | |
| **REQUEST FOR DANE COUNTY SUPPORT BROKER TO ATTEND ENROLLMENT COUNSELING SESSION** | | | | |
| Service providers are not allowed to attend enrollment counseling in Wisconsin’s Medicaid long-term care system. There has been a request, based upon the historical model used in Dane County where members may rely on support brokers to assist in managing services, to allow support brokers to attend enrollment-counseling sessions when the member requests the support broker’s attendance. Therefore, the Wisconsin Department of Health Services will allow support brokers in Dane County to attend a member’s enrollment counseling session only during the transition for waiver enrollees from the legacy waiver programs to the Family Care, IRIS or Partnership programs if the member requests that the support broker attend and the support broker discloses any conflict of interest. | | | | |
| **Support Broker Attestation:** Please enter your name, initial next to the statement that applies, sign and date: | | | | |
| Failure to accurately complete or abide by this attestation may negatively impact the support broker’s ability to provide paid services in the Family Care, IRIS or Partnership programs in the future. | | | | |
| I,       , am a support broker in the current Dane County CIP and/or COP program. | | | | |
| Name | |  | | |
| My future employment or financial relationship with Family Care, IRIS or Family Care Partnership is as follows: | | | | |
|  | I will not work or provide paid services for the Family Care, IRIS or Family Care Partnership program. | | | |
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|  | I plan to seek employment in or to provide paid services for the Family Care, IRIS or Family Care Partnership programs in Dane County, but do not currently have any arrangement to do so. | | | |
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|  | I have a contract or the agency I currently work for has a contract, to provide services in the Family Care, IRIS or Family Care Partnership program. The provider agency I expect to work for is | | | |
|  | . | | | |
|  | (Name of Managed Care Organization, IRIS Consultant Agency or Fiscal Employer Agency | | | |
| I will not try to influence the CIP/COP participant in his/her decision making process during the enrollment counseling session or at any other time.  If the Aging and Disability Resource Center (ADRC) staff person believes that my involvement in the enrollment counselling session interferes with the participant’s ability to make a free and knowing choice, I may be asked to leave the session, and I agree to voluntarily comply. | | | | |
| **SIGNATURE** – Support Broker | | | | Date Signed |
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| **Member Attestation:** | | | | |
| I,       , have read and understand the above statement and recognize that the support broker may have a financial interest in which program I choose. I request that       (Name of Support Broker) attend the enrollment counseling session knowing he/she may have a conflict of interest but still choose to allow him or her to participate. I recognize that if I feel any undue influence I can at any point ask the support broker to leave the counseling session. I also recognize I can call the ADRC at any time to discuss my concerns or change my enrollment choice. | | | | |
| **SIGNATURE** – Member | | | | Date Signed |
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| **SIGNATURE** – Guardian/Representative (if applicable) | | | | Date Signed |
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