

Dear Caregiver Applicant:

Thank you for your interest in becoming a paid caregiver for a Rock County Children's Long-Term Support (CLTS) family through our fiscal agent program. This program allows CLTS families to employ trusted individuals such as yourself to provide them with much-needed services. These services are funded by Rock County Human Services but paid by KCC Fiscal Agent Services in the form of a paycheck to you.

Enclosed please find all the paperwork necessary to apply. The checklist on the first page outlines all the forms.

Once you have completed all the paperwork, please give back to your employer family—they will then complete and sign the necessary forms, and submit everything to KCC Fiscal Agent Services for processing.

TIMESHEET INFORMATION FOR YOU

All payments are made by check. There are two pay periods in a month. 1-15 and 16-30.

Here is an example of how payments are made and deadlines to submit are determined.

Pay Period of January 1 – January 15

Time sheets are due on January 20th (5 days after the pay period ends)

Payment is then scheduled for January 30th (10 days after the time sheet is due)

Pay Period of January 16 – January 31

Time sheets are due on February 5th (5 days after the pay period ends)

Payment is then scheduled for February 15th (10 days after the time sheet is due)

Thank you again for your interest!

Rock County Human Services Department: Children's Long Term Support

PROVIDER PAPERWORK

Child Name _____ Child Date of Birth _____

	Provider Initials
I have received and understand the SPC for the service that I will be providing.	
I received, completed and submitted the CLTS Waivers Qualified Provider Standards Verification for each service I will be providing.	
I have received and will read the following handouts: <ul style="list-style-type: none"> * Communicating With and About People With Disabilities * Pro-Active Approach * Client Rights * Respecting Client Choices * Recognizing & Responding to Emergencies * CLTS Overnight Respite Policy and Procedure 	
I received and understand my role and responsibility in Critical Incident Reporting and have the contact information for reporting Critical Incidents as well as the information for reporting any concerns of child/adult physical, verbal and sexual abuse, maltreatment, neglect and financial exploitation.	
I have completed and submitted the W-4 form.	
I have completed, signed and submitted the Wisconsin Medicaid Program Provider Agreement and Acknowledgment of Terms of Participation. F-00180B	
I received blank copies of the timesheets that require completion in order to be reimbursed for services. I understand that the timesheets are to be filled out with the accurate dates and times to the best of my knowledge and belief and must be signed by myself and the parent/guardian of the client or the client (if 18 or over). I understand that timesheets need to be submitted by me to the fiscal agent in a timely manner. Any timesheets that are believed to be fraudulent or falsified will be referred to law enforcement officials.	
I have completed, signed and submitted the Vehicle Liability Insurance Verification form.	
I have received and understand the Program Fraud Prevention information provided.	

I understand that my signature indicates that I have received copies as indicated and that I understand the information as noted. Refusal to sign any of the forms or falsifying information can affect approval for reimbursement for hours provided through the CLTS Waiver Services.

Child Signature _____ Date _____
 (If Child is 14 and over)

Parent/Guardian Signature _____ Date _____

Provider Signature _____ Date _____

Rock County Human Services Department: Children's Long Term Support

EMPLOYER AGREEMENT

Child Name _____ Child Date of Birth _____

I understand that the caregiver is hired by me and is not an employee of Rock County Human Services.
I understand my caregiver will receive a paycheck for services through KCC Fiscal Agent under contract with Rock County Human Services. Payment is based on caregiver's completion and submission of provided timesheets on a monthly or twice monthly basis.
I understand that I am responsible for caregiver training and monitoring.
I understand that if my child is in an ineligible setting (hospital, secure detention, psychiatric facility) services cannot be provided.
I understand that this program relies on federal funding and I am responsible for preventing and reporting fraud.

EMPLOYERS SIGNATURES:

Child Signature _____ Date _____
(If Child is 14 and over)

Parent/Guardian Signature _____ Date _____

**WISCONSIN MEDICAID
CHILDREN'S LONG-TERM SUPPORT (CLTS) WAIVER PROGRAM
PROVIDER AGREEMENT AND ACKNOWLEDGEMENT OF TERMS OF PARTICIPATION
FOR SOLE PROPRIETOR OR INDIVIDUAL WAIVER SERVICE PROVIDERS¹**

Completion of this form is required under Federal Law by the Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services, under the Code of Federal Regulations 42 CFR 431.107.

Name of Provider (Typed or Printed)		Phone Number	
Email Address			
Line 1 Street Address (physical address)	Line 2 Street Address		
Mailing Address (if applicable)	City	State	Zip Code

The sole proprietor provider's name, as listed above, must exactly match the name on file with the Wisconsin Department of Health Services (DHS), the U.S. Internal Revenue Service (IRS) and/or Wisconsin Department of Revenue. The above-referenced provider hereby agrees and acknowledges it will:

1. Comply with certain federal and state Medicaid home and community-based services (HCBS) laws, regulations and policies, including those relating to § 1915(c) of the Social Security Act and Title XIX, those regulations pertinent to Wisconsin's Medicaid program, official written policy as transmitted to the provider through the CLTS Waiver Program's published memos, handbooks and other communicate, the standards for the specific CLTS waiver service the provider will deliver, and other requirements as defined in the Wisconsin Medicaid Home and Community-Based Waivers Manual. The provider acknowledges it is responsible for knowing the provisions of federal and state laws, regulations, the applicable CLTS Waiver Program policies, and for complying with all applicable federal and state laws as a condition of its participation as a provider of Wisconsin's Medicaid-funded CLTS Waiver Program.
2. Register and submit all required data to DHS, including its National Provider Identifier (NPI). The provider will submit information updates, as necessary, to ensure accurate data is on file with DHS. Re-registration and an updated signed *CLTS Waiver Program Medicaid Provider Agreement* form must be submitted every four years, at a minimum. The CLTS Waiver Program registration site is available at: <https://www.dhs.wisconsin.gov/clts/providers.htm>.
3. Comply with all federal and state laws regarding confidentiality and disclosure of personal health information (PHI) and personal identity information (PII) including the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for all services, transactions (including electronic transactions), privacy, and security regulations.
4. Retain any records necessary to fully document the services delivered to participants, in accordance with 42 CFR § 431.107 of the federal Medicaid regulations, for a period of seven years. See DHS 106.02, Wis. Administrative Code for state policy related to provider record retention.
5. Upon request the provider shall furnish to DHS, the Wisconsin Department of Justice Medicaid Fraud Control Unit, or the U.S. Department of Health and Human Services (DHHS) any information regarding CLTS Waiver Program services delivered and payments claimed by the provider.
6. Comply with the disclosure requirements of 42 CFR Part 455, Subpart B in effect now, or as may be amended. To meet those requirements and address real or potential conflict of interest that may influence service provision, furnish to the county waiver agency (CWA) and upon request to DHS, the following in writing:
 - a. The names and addresses of all vendors of drugs, medical supplies or transportation, or other providers in which it has a controlling interest or ownership;
 - b. The names and addresses of all persons who own or have a controlling interest in the provider;
 - c. Whether any of the persons named in compliance with (a) and (b) above are related to any owner or to a person with a controlling interest as spouse, parent, child or sibling;
 - d. The names and addresses of any subcontractors who have had business transactions with the provider;
 - e. The identity of any person, named in compliance with (a) and (b) above, who has been convicted of a criminal

¹ Note: This agreement is intended for use by providers who are sole proprietors or individuals who are unaffiliated with a provider agency or service.

offense related to that person's involvement in any program under Medicare, Medicaid or Title XIX services programs since the inception of those programs.

7. Affirm each employed and/or sub-contracted individual that delivers CLTS waiver services to eligible participants, hold current licenses, registrations, certifications and/or similar entitlements, and meets the qualifications specified in the CLTS Waiver Manual, P-02256, as required by federal or state statute, regulation, or rule for the provision of the service. In addition, the provider has completed all required screening activities, including a search of the U.S. DHHS Office of Inspector General's List of Excluded Individuals/Entities (LEIE), and conducted Wisconsin caregiver background checks for all employees or sub-contractors with regular, direct access to CLTS waiver participants.²
8. Consent to the use of statistical sampling and extrapolation as the means to determine the amounts owed by the provider to the Medicaid program as a result of an investigation or audit conducted by DHS, the Department of Justice Medicaid Fraud Control Unit, the U.S. Department of Health and Human Services, the Federal Bureau of Investigation, or an authorized agent of any of these entities.
9. Submit to the CWA or DHS any information it requests to ensure qualified providers delivered prior authorized CLTS waiver allowed services to eligible participants. Failure to supply the information requested by DHS result in denial of CLTS Waiver Program payment or sanctions related to the provider's continued participation in the program.
10. Affirm any statement made in this document, or during the DHS registration and CWA qualified provider screening and verification process, constitutes a statement or representation of a material fact made in an application for a benefit or payment, or made for use in determining rights to such benefit or payment, that is knowingly and willfully made or caused to be made by provider, within the meaning of Wis. Stat. § 49.49 (1)(a) 1 and 2, which imposes criminal penalties for fraud committed in connection with a Medicaid Program.
11. Affirm claims are only submitted for allowable CLTS waiver services to participants, which were included on the eligible participant's Individual Service Plan (ISP), are prior authorized by the CWA, and delivered to the participant. With the exception of supplemental CLTS covered child care expenses, the provider agency is prohibited from billing the CLTS Waiver Program participant, or the participant's parent/guardian, for any portion of the cost of the prior authorized waiver service.
12. Accept as payment in full, amounts paid in accordance with the CLTS rate schedule established by DHS for in-scope services: <https://www.dhs.wisconsin.gov/publications/p02184.pdf>
13. Submit claims and receive direct payment from the DHS third party administration (TPA) CLTS claims processing vendor, Wisconsin Physician Services (WPS), pursuant to 42 CFR § 447.10(e). The service payment is based on the CWA's prior authorization of specified waiver services for each eligible CLTS waiver participant.
14. Submit all claims to the TPA within 120 days from the date of service, or in the instance of services covered by a private insurance carrier or Medicare, submit the service claims within 120 days from the date of the third party's explanation of benefit (EOB) statement.
15. Submit refunds to WPS for any overpayments identified by the CWA, WPS or DHS.
16. This agreement may be terminated as follows:
 - a. By the provider as set forth at s. DHS 106.05, Wisconsin Administrative Code.
 - b. By the Department upon grounds set forth at s. DHS 106.06, Wisconsin Administrative Code.
 - c. Pursuant to terms set forth in the Wisconsin Medicaid Home and Community-Based Waivers Manual.
17. Unless terminated earlier, this agreement shall remain in full force and effect for a maximum of four years. This agreement shall not extend beyond the due date of the four year re-registration requirements. DHS will issue notification when the four-year re-registration requirement is due.

MODIFICATIONS TO THIS CLTS WAIVER PROGRAM AGREEMENT ARE NOT PERMITTED. THIS AGREEMENT IS NOT TRANSFERABLE OR ASSIGNABLE TO ANOTHER PARTY.

Name – Provider – Sole Proprietor (Typed or Printed)	Title – Owner/Operator
SIGNATURE – Provider	Date Signed

² Qualified provider screening and credential verification and approval is a local county waiver agency function, whereby every four years, at a minimum, the agency must assess and ensure the provider continues to meet all applicable CLTS Waiver Program service standards.

Employee's Withholding Certificate

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.

Give Form W-4 to your employer.

Your withholding is subject to review by the IRS.

2024

Step 1: Enter Personal Information	(a) First name and middle initial	Last name	(b) Social security number
	Address		Does your name match the name on your social security card? If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to www.ssa.gov .
	City or town, state, and ZIP code		
	(c) <input type="checkbox"/> Single or Married filing separately <input type="checkbox"/> Married filing jointly or Qualifying surviving spouse <input type="checkbox"/> Head of household (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)		

Complete Steps 2-4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, and when to use the estimator at www.irs.gov/W4App.

Step 2: Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Multiple Jobs or Spouse Works

Do **only one** of the following.

(a) Use the estimator at www.irs.gov/W4App for most accurate withholding for this step (and Steps 3-4). If you or your spouse have self-employment income, use this option; **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate

Complete Steps 3-4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3-4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependent and Other Credits	If your total income will be \$200,000 or less (\$400,000 or less if married filing jointly):		
	Multiply the number of qualifying children under age 17 by \$2,000	\$	
	Multiply the number of other dependents by \$500	\$	
	Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here	3	\$
Step 4 (optional): Other Adjustments	(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income	4(a)	\$
	(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here	4(b)	\$
	(c) Extra withholding. Enter any additional tax you want withheld each pay period	4(c)	\$

Step 5: Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.

Sign Here

Employee's signature (This form is not valid unless you sign it.)

Date

Employers Only	Employer's name and address	First date of employment	Employer identification number (EIN)

General Instructions

Section references are to the Internal Revenue Code.

Future Developments

For the latest information about developments related to Form W-4, such as legislation enacted after it was published, go to www.irs.gov/FormW4.

Purpose of Form

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. If too little is withheld, you will generally owe tax when you file your tax return and may owe a penalty. If too much is withheld, you will generally be due a refund. Complete a new Form W-4 when changes to your personal or financial situation would change the entries on the form. For more information on withholding and when you must furnish a new Form W-4, see Pub. 505, Tax Withholding and Estimated Tax.

Exemption from withholding. You may claim exemption from withholding for 2024 if you meet both of the following conditions: you had no federal income tax liability in 2023 **and** you expect to have no federal income tax liability in 2024. You had no federal income tax liability in 2023 if (1) your total tax on line 24 on your 2023 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2024 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 15, 2025.

Your privacy. Steps 2(c) and 4(a) ask for information regarding income you received from sources other than the job associated with this Form W-4. If you have concerns with providing the information asked for in Step 2(c), you may choose Step 2(b) as an alternative; if you have concerns with providing the information asked for in Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c) as an alternative.

When to use the estimator. Consider using the estimator at www.irs.gov/W4App if you:

1. Expect to work only part of the year;
2. Receive dividends, capital gains, social security, bonuses, or business income, or are subject to the Additional Medicare Tax or Net Investment Income Tax; or
3. Prefer the most accurate withholding for multiple job situations.

Self-employment. Generally, you will owe both income and self-employment taxes on any self-employment income you receive separate from the wages you receive as an employee. If you want to pay these taxes through withholding from your wages, use the estimator at www.irs.gov/W4App to figure the amount to have withheld.

Nonresident alien. If you're a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Specific Instructions

Step 1(c). Check your anticipated filing status. This will determine the standard deduction and tax rates used to compute your withholding.

Step 2. Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work.

Option (a) most accurately calculates the additional tax you need to have withheld, while option (b) does so with a little less accuracy.

Instead, if you (and your spouse) have a total of only two jobs, you may check the box in option (c). The box must also be checked on the Form W-4 for the other job. If the box is checked, the standard deduction and tax brackets will be cut in half for each job to calculate withholding. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount will be larger the greater the difference in pay is between the two jobs.



Multiple jobs. Complete Steps 3 through 4(b) on only one Form W-4. Withholding will be most accurate if you do this on the Form W-4 for the highest paying job.

Step 3. This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 501, Dependents, Standard Deduction, and Filing Information. You can also include **other tax credits** for which you are eligible in this step, such as the foreign tax credit and the education tax credits. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

Step 4(a). Enter in this step the total of your other estimated income for the year, if any. You shouldn't include income from any jobs or self-employment. If you complete Step 4(a), you likely won't have to make estimated tax payments for that income. If you prefer to pay estimated tax rather than having tax on other income withheld from your paycheck, see Form 1040-ES, Estimated Tax for Individuals.

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2024 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

Step 4(c). Enter in this step any additional tax you want withheld from your pay **each pay period**, including any amounts from the Multiple Jobs Worksheet, line 4. Entering an amount here will reduce your paycheck and will either increase your refund or reduce any amount of tax that you owe.

Complete if providing
transportation to client(s)

CLTS Vehicle Liability Insurance Verification

Provider Name: _____ Provider DOB: _____

Street Address: _____

City, State, Zip: _____

The Rock County Human Services Department requires that CLTS providers have a valid driver's license and auto liability insurance if they are transporting CLTS participants during a paid service. So that we may verify your driver's license and that your policy is in effect, please provide the information below. This form gives the Rock County Human Services Department permission to verify you hold a valid driver's license and to contact your insurance company to request the information as needed.

Driver's License Number: _____

Name of Insurance Company: _____

Agent Name: _____

Insurance Company Phone Number: _____

I (provider) agree to keep the policy in effect during the time I am providing services for CLTS. If, for any reason, the policy lapses or is cancelled, I agree to notify the Rock County Human Services Department immediately. The information needs to be provided to the Rock County Human Services Department at every policy renewal or change of insurance company.

Provider Signature

Date

I (parent) grant permission for the above provider to transport my child(ren) during a paid service.

Parent Signature

Date

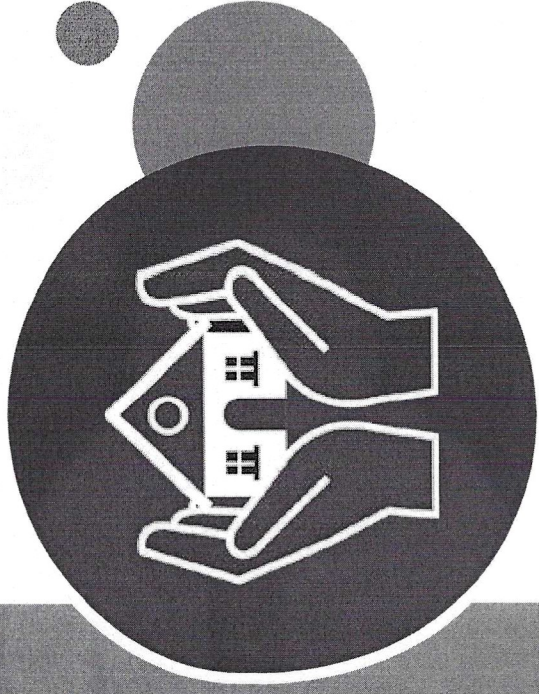
This form is in effect for one year from date of signature(s).

Call the support and service coordinator (SSC) when incidents happen.

Name

Phone Number

Notes



Family Guide to Incident Reporting

Keeping children safe.

In everyday life, incidents can happen that affect a child's safety. You need to report incidents that threaten the child's physical health, mental health, safety or well-being. Reporting an incident can help keep the child safe and stop it from happening again.



Division of Medicaid Services
Bureau of Children's Services
dhs.wisconsin.gov

P-00069A (02/2022)

Children's Long-Term Support
(CLTS) Program

Children's Community
Options Program (CCOP)

What is an incident?

An incident is an event or situation that creates risk or harm to the physical health, mental health, safety or well-being of a child. An incident is an event that:

- Has happened.
- Is suspected, or thought, to have happened.
- Is threatened to happen.

Why report incidents?

An incident is reported to help support the safety and well-being of children enrolled in the CLTS Program or CCOP. Families and providers are required to report incidents to the support and service coordinator (SSC).

The SSC can help your family make sure you are receiving the services and supports to help the child stay safe.

When should you call?

Call the SSC as soon as possible. Reporting an incident as soon as possible helps the child and your family receive the supports and services needed to help keep the child safe.

If you are not sure if an incident needs to be reported, please ask the SSC for help.

What happens next?

- The SSC will ask you and your family about what has happened or may have happened, and help you explore ways to support the child and prevent future incidents. It may also be a helpful time to review the child's supports and services.
- The SSC will inform the Wisconsin Department of Health Services (DHS) about the incident and what steps are being taken to help protect the child.

What if it is an emergency?

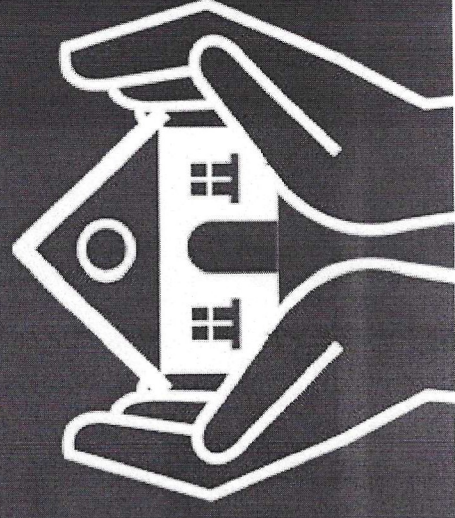
- Call 911 immediately if the child is still at risk of harm and needs help!
- Notify the SSC in addition to any other professionals that may be involved, such as law enforcement or child protective services.

Examples of Incidents

- The child has been or is suspected of being abused, neglected, or exploited.
- The child is physically restrained by a CLTS or CCOP Provider.
- The child is suicidal and is admitted to a hospital.
- The child is given the wrong medicine and is admitted to the hospital.
- The child has contact with law enforcement.

These are just a few examples of incidents.

Be sure to report any situation where the child has been harmed or is at risk of being harmed.



**Children's Long Term Support (CLTS) Waivers
CRITICAL INCIDENT REPORTING OVERVIEW**

What is a critical incident?

A critical incident is any actual or alleged event or situation that creates a significant risk or serious harm to the physical, mental health, safety, or well-being of your child. The critical incidents that must be reported to your Support and Service Coordinator include:

- Any abuse or neglect of the child known or suspected.
- Errors in medical or medication management that result in a significant adverse reaction that requires medical attention.
- The initiation of an investigation by law enforcement of an event or allegation regarding a child as either a perpetrator or victim, unless such action is a component of an approved crisis or treatment plan.
- Significant and substantial damage to the residence of the child or service provider.
- Use of isolation, seclusion, or restraint by a service provider which is not included and approved as part of a behavior support plan.
- An unexpected event or behavior that causes a serious injury or risk to the child; which may include running away, setting a fire, violence, hospitalization resulting from an accident, suspected or confirmed suicide attempts, or death of the child.

If any of these incidents occur, please contact your Support and Service Coordinator.

Contact Name and Phone Number: _____

Why is a critical incident reported?

- The assurance of health, safety, and welfare of your child is a condition of all Medicaid Waivers by the federal Centers for Medicare and Medicaid Services.
- One of the ways both the State and contracted agents assure health, safety, and welfare of your child is by individually reporting, monitoring, and resolving critical incidents.
- To address incidents as they occur and decrease the likelihood of a recurrence.

How is a critical incident reported?

- As soon as possible, families and providers are required to report critical incidents to their agency Support and Service Coordinator.
- Agency Support and Service Coordinators are required to immediately report critical incidents to the State staff responsible for the CLTS Waiver program to ensure necessary steps have been taken to protect the child and assure safety.
- Agency Support and Service Coordinators are required to submit a final report within 30 days of the incident.

What happens after a critical incident is reported?

- Support and Service Coordinators are expected to address and resolve situations and implement systems to decrease the likelihood of a recurrence.
- The State staff responsible for the CLTS Waiver program will use information collected in critical incident reports to identify statewide or regional trends, which will then allow for the development of training or interventions to decrease the likelihood of recurrence.

If a critical incident occurs, families and providers should seek all necessary care and assistance from medical or emergency personnel as appropriate. This reporting procedure does not provide an immediate response or replace other mandatory reporting expected of agency personnel.

- The waiver agency is required to inform parents/guardians of any reported incidents. Parents or guardians must be informed of the event within twenty four (24) hours of time and date of the waiver agency's report to the state. If the incident involves a crime (such as abuse, neglect, exploitation, child abuse, theft of property or funds, sexual assault, assault or theft), the applicable law enforcement and protective service agencies must be notified.

Child Protective Services Reporting

In the event that you need to make a report of abuse or neglect, of a child under the age of 18, to the Rock County Human Services Department: Child Protective Services, you can call directly to 1-608-757-5401 Monday through Friday, 8am to 5pm.

If it is after those hours or on a holiday call the Rock County non-emergency number at 1-608-757-2244 and ask to speak to the CPS on call after hour's worker.

If there is an immediate health and/or safety concern, call 911 for a more immediate response.

Child Protective Services is a specialized field of the Child Welfare System. CPS intervention is warranted whenever there is a report of a child that may be unsafe, abused, neglected, or be at risk of abuse or neglect.

Physical abuse is defined in s. 48.02 (1)(a), Stats., as "Physical injury inflicted on a child other than accidental means." "Physical injury" includes but is not limited to lacerations, fractured bones, burns, internal injuries, severe or frequent bruising or great bodily harm as defined under s. 939.22 (14)."

Neglect is defined in s. 48.981 (1)(d), Stats., as "failure, refusal or inability on the part of a caregiver, for reasons other than poverty, to provide necessary care, food, clothing, medical or dental care or shelter so as to seriously endanger the physical health of the child."

Sexual abuse: there are two general types of sexual contact and sexual intercourse:

- Where a child, male or female, is assaulted or otherwise victimized, exploited or coerced by another person, either an adult or child
- Where a child, male or female, is engaging in mutual sexual activity with a peer, but the child is not old enough to consent under Wisconsin laws

Adult Protective Services Reporting

In the event that you need to make a report of abuse or neglect, of an individual over the age of 18, to the Rock County Aging and Disability Resource Center (ADRC), you can call directly to 1-608-741-3600 or toll free at 855-741-3600 Monday through Friday, 8am to 4:30pm. After those hours or on holidays, you can call Crisis Intervention at 1-608-757-5025.

If there is an immediate health and/or safety concern, call 911 for a more immediate response.

Physical abuse: intentional or reckless infliction of physical pain or injury, illness, or any impairment of physical condition.

Emotional Abuse: language or behavior that serves no legitimate purpose and is intended to intimidate, humiliate, threaten, frighten, or otherwise harass the individual to whom the conduct or language is directed.

Sexual Abuse: sexual contact or intercourse with another person without consent (a violation of criminal assault law, §940.225 (1), (2), (3), or (3m)).

Treatment without Consent: the administration of medication or the performance of psychosurgery, electro-convulsive therapy, or experimental research on an individual who has not provided informed consent, with the knowledge that no lawful authority exists for the administration or performance.

Unreasonable Confinement or Restraint: the intentional and unnecessary confinement of an individual in a locked room, involuntary separation from his or her living area, use of physical restraints, or the provision of unnecessary or excessive medication. (Note: This does not include the use of these methods or devices if they conform to state and federal standards governing confinement and restraint.)



FOR YOUR INFORMATION

FRAUD AND ABUSE PREVENTION

Prevention of fraud, abuse and neglect are vital to maintaining integrity within the Self Directed Support Program. Fraud diverts funds that could be otherwise allocated in other positive ways to assist those in need of care. As a recipient of funds, guardian, representative, care provider or participant, you are required to adhere to State and Federal laws to prevent misuse or fraud.

Fraud and abuse of Medicaid is when a person knowingly cheats or is dishonest. Abuse includes any practice that is inconsistent with acceptable practices and unnecessarily increases costs.

Examples of fraud and abuse may include:

- Recording any hours on a time sheet when service was not provided
- Making changes to a time sheet after it has been approved
- Employee stating that they performed cares that were not actually performed
- Recording hours at times different from service actually provided
- Approving or authorizing hours that an employee did not actually complete

When a person intends to cheat or be dishonest, that is fraud and abuse. Medicaid fraud is intentionally misrepresenting the facts to obtain unauthorized benefits.

It is the duty and responsibility of a recipient of funds, guardian, representative, care provider or participant to report suspected fraud and abuse of Medicaid. How to report – 1 877-865-3432 or <https://www.dhs.wisconsin.gov/fraud/index.htm>.