IRIS
Include, Respect,
I Self-Direct

Wisconsin's Self-Directed Supports Program

☐ **Employee New Hire Form** ☐ **Status Change Form**

Start Date: __ __ /__ __ / 20 __ __ Termination Date: __ __ /__ __ / 20 __ __

Employee Name: _____
Last First M.I.
Street Address: _____

City: _____ State: _____ Zip: _____

Phone: __ __ __ - __ __ __ - __ __ __ __ Birth Date: __ __ /__ __ / __ __ __ __

Social Security Number: __ __ __ - __ __ - __ __ __ __ ☐ Male ☐ Female

Are you the Participant's: ☐ Parent/Guardian ☐ Parent ☐ Guardian ☐ Spouse
☐ Domestic Partner ☐ Stepparent ☐ Sibling ☐ Child ☐ Stepchild
☐ Grandparent ☐ Grandchild ☐ Other Relative ☐ Friend/Neighbor
☐ Other Worker: _____

E-mail Address: _____

This Employee will work as a: ☐ CNA ☐ LPN ☐ RN ☐ Personal Care Worker
☐ Supportive Home Care Worker ☐ Respite ☐ Other
(If employed as a CNA, LPN, or RN, please attach a copy of the license for verification.)

Pay Rate/s: _____ Mileage Rate: _____

Participant's Name: _____
Last First M.
Street Address: _____

City: _____ State: _____ Zip: _____

Phone: __ __ __ - __ __ __ - __ __ __ __

Employee Signature: _____ Date: __ __ /__ __ / 20 __ __

Participant Signature: _____ Date: __ __ /__ __ / 20 __ __

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