Wisconsin's Self-Directed Supports Program

Provider Agreement

I, ______________________________________, hereafter referred to as participant, and ___________________________________, hereby referred to as provider, do hereby enter into the following agreement:

The participant requires the following tasks and duties to be performed by the provider:

The provider agrees to provide/arrange for training and orientation any needed by employees as described below:

The provider agrees to preform the tasks as outlined above according to the schedule of:
☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday
☐ Sunday ☐ Other: ____

Services will be provided at the rate of $_________ per ☐ Hour ☐ Day ☐ Week
☐ Other: ____

I understand that these services are provided under Medicare regulations and that I may not charge in excess of the amount agreed upon with this document.

Provider FEIN: ____
Name: ____
Street Address: ____
City: _______________________________________ State: ________ Zip: __________
Phone: __ __ __ - __ __ __ - __ __ __ __

Participant Signature: ____________________________ Date: __ __ /__ __ / 20 __ __

Provider Signature: ______________________________ Date: __ __ /__ __ / 20 __ __

Invoices can be emailed to IRIS@mcfi.net, faxed to 414-937-2034 or mailed to:
IRIS Financial Services Agency, % MCFI Fiscal Agent, 2020 W. Wells St., Milwaukee, WI 53233