

Being a FULL PARTNER

Important information for Family Care
and Partnership members and
others who want information about
these programs



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Welcome

If you recently made the decision to enroll in Family Care or Family Care Partnership (Partnership), this booklet will provide you with information about being a member. If you are still working with your local Aging and Disability Resource Center (ADRC) to determine the best program for you, this booklet can be a source of information to help you make your choice.

This booklet is also for family members, guardians and health care professionals who are helping a member make decisions or who have legal responsibility to make decisions on the member's behalf.

This booklet explains your role as a member of the Family Care or Partnership program. A main goal of these programs is to ensure that people with long-term care needs are safe and cared for in their own homes and communities whenever possible.

The end of this booklet contains a Glossary of Terms. The glossary can help you understand the words and phrases frequently used in this booklet.

Introduction

Once you enroll in Family Care or Partnership, you become a “member” of the program. The word “you” is used in this booklet to refer to a Family Care or Partnership member or potential member.

The Family Care and Partnership programs are funded by state and federal tax dollars. The State of Wisconsin Department of Health Services contracts with Managed Care Organizations (MCOs) to operate these long-term care programs. They are agencies that provide or coordinate a wide range of health and long-term support services to people who are eligible and choose to enroll.

In Family Care and Partnership, each MCO receives a monthly payment from the State of Wisconsin for each member. The MCO then pools the money and uses it to

provide individually planned services for all of its members.

Sometimes members are required to pay a share of the cost of the services they receive. This is called “cost share” or “spend down.” If you will have a cost share or spend down, staff from the ADRC will discuss this with you before you make a final decision about enrolling.

Each MCO has a Member Handbook (called the Evidence of Coverage booklet in Partnership) that provides more information about MCO services and member rights. The MCO is required to give the Member Handbook and information about how to get a list of the providers it routinely uses (called the provider network list) to each member. This information is to show you the whole range of services and providers available to all members. It does not mean that you can get a service that is listed just because you are a member. You and your care team will determine which services are appropriate for your care plan.

What are Family Care and Partnership?

Family Care and Partnership are health and long-term care programs available in most areas of the state. Your local ADRC can tell you what programs are available in your area.

Both Family Care and Partnership are voluntary and offer you cost-effective choices in where you receive services and focus on your own goals for your health and quality of life. Family Care provides a wide range of health and long-term care services. Partnership adds medical care to the long-term support services available in Family Care. The specific services each member receives is based on his or her unique needs.

Most people in Family Care and Partnership choose to live in their own homes or in other community settings. This allows people to have more control over their lives and be more involved with their communities. Whether you live in a house, apartment, mobile home, or assisted living, your team will work with you to find the best living situation.

What does being a “full partner” mean?

As a member, you have the right and responsibility to be a full partner in deciding what you need for your health and long-term support services, and in planning how those services will be provided to you.

Being a **full partner** in your care plan means you have the right to:

- Participate in decisions that affect your own care.
- Choose to involve family members or other people that are important to you.
- Describe your most important support needs, and what you want your life to be like.
- Know the different services and supports that are available and how much they cost. You can also suggest other services or supports that you think would meet your needs.

- Get help from your MCO to make choices about your services and supports.

As a full partner, you also have the responsibility to:

- Meet with your care team face-to-face to discuss your needs, outcomes and preferences.
- Choose among the cost-effective options that are available to meet your needs.
- Identify the support your family and friends currently provide, and what they can continue to provide.

Who is involved in the planning process?

When you enroll in Family Care or Partnership, a team of people will help you identify the assistance you need and arrange your long-term care services. This is your care team and it includes:

- You;
- A registered nurse and a care manager assigned by the MCO;

- Anyone you want to have involved, such as a family member, friend, or a person who works on your behalf, such as an advocate; and
- Other professionals such as an occupational therapist, physical therapist, or mental health specialist may be involved, depending on your needs.

In Partnership, your care team is the same as in Family Care, but also includes a nurse practitioner, who coordinates care with your doctor.

The job of the care team is to work with you to:

- Identify your health needs and long-term care outcomes.
- Develop a member-centered plan that outlines the services and other help you need to support those outcomes.
- Ensure your services meet your needs and are cost-effective.

- Make sure the services in your plan are actually provided to you.
- Make sure the plan continues to work for you.

You should be involved in every part of the process, and you should get any extra help you need in order to take part in the process, such as an interpreter or a person to read to you.

If you have a guardian or activated power of attorney for health care, that person will be involved in planning along with you, will give the legal consent for your services, and will work with you and the rest of the care team to make sure that your voice is heard and respected.

How will your care team know what is important to you?

You and your care team will do an **assessment** of your needs, strengths and preferences. Part of this process is for you to tell your care team:

- The kind of life you want to live.
- The kind of support you need to live the kind of life you want.

The assessment gives your team a clear understanding of what is important to you.

During the assessment, your team will help you identify your **personal experience outcomes**. These outcomes are the goals you have for your own life and they include:

- Input on:
 - Where and with whom to live;
 - Needed supports and services; and
 - Your daily routines.
- Personal Experience – having:
 - Interaction with family and friends;
 - A job or other meaningful activities;
 - Community involvement;

- Stability;
- Respect and fairness; and
- Privacy.
- Health and Safety – being:
 - Healthy;
 - Safe; and
 - Free from abuse and neglect.

Only you can tell your team what's important to you. YOU define what these outcome statements mean to you and your life. For example, a person might want to:

- Be healthy enough to enjoy visits with his or her grandchildren;
- Have a paid job; or
- Be independent enough to live in his or her own apartment.

You have a right to expect that your care team will work with you to identify your personal experience outcomes.

However, this does not mean the MCO will always buy services to help you achieve your goals. Family Care and Partnership may not be able to help you get everything you want out of life. The things you do for yourself, or that your family and friends do for you, will still be an important part of your care plan.

How do you and your care team decide what support you need?

During the assessment process, you and your team will also identify your **long-term care outcomes**. This helps you and your team know what services and supports will meet your long-term care needs.

Long-term care outcomes are those things Family Care and Partnership can help you achieve and have the kind of life you want. For example:

- Receiving health care;
- Being able to get your daily needs met;

- Having a job; and
- Getting what you need to stay safe, healthy and as independent as possible.

Having these things in place will let you focus on the people and activities that are most important to you. For example, getting help to dress or take a bath may also help a person feel well enough to go to work or visit family and friends.

The MCO has to consider cost-effectiveness when authorizing services. Cost-effective means effectively supporting an identified long-term care outcome at a reasonable cost and effort. For example, if two different providers offer the assistance you need, the MCO will purchase the more economical service.

Most MCOs use the Resource Allocation Decision (RAD) process as a guide in making decisions about services. The RAD is a step-by-step tool you and your team will use to help determine the most effective and cost-effective way to support your long-term care outcomes.

How do Family Care and Partnership involve your family and friends?

Family Care and Partnership encourage family members, friends and other people that are important to you to be involved in your care. For example, you can choose to include them on your care team and come with you when you meet with your MCO.

Family Care and Partnership do not replace the help you get from your own support network. A person's support network might include:

- Family and friends;
- Neighbors;
- Volunteers;
- Church members; and
- Community resources, such as libraries, clubs and senior centers.

The MCO purchases services that your own supports cannot provide. Building on, instead of replacing, the assistance you get from your support network strengthens these invaluable relationships and helps MCOs pay for services where and when they are needed.

Your MCO will help find ways to strengthen your support network. For example, if the people who help you need a break, the MCO can provide respite services. Respite provides a temporary break for your caregivers to give them time to relax and maintain their own health.

If you do not currently have any natural or community supports, your care team will help you identify other supports or relationships that can be developed.

What should be covered in your member-centered plan?

Your care team will develop a member-centered plan that will help you move toward the outcomes that you and your

team identified in the assessment process. The plan must be clear about:

- Your physical health needs and your ability to perform certain tasks and activities (such as eating and dressing);
- Your strengths and preferences;
- Your personal and long-term care outcomes;
- The services you will receive to support your outcomes;
- Who is going to provide you with each service or support;
- How often you will meet with your care team;
- When you and your care team will review and update your member-centered plan; and
- The things you are going to do yourself or with help from family or friends.

You will meet regularly with your care team to talk about how you are doing and to evaluate if your services and supports are helping you. Your team will ask you to sign your plan, which shows you participated in its development. The MCO must give you a copy of your plan. If you are not happy with your plan, you can file a grievance or appeal (see the section, “What choices do you have if you want to file a grievance or appeal?”).

Your member-centered plan can change as your needs and life circumstances change. For example, your services may decrease if your physical health improves. Family Care and Partnership services are designed to be flexible and change over time and adjust to your needs. If you have a change in your life that affects your needs or outcomes, you should contact your care team. When your care team knows about these changes, your member-centered plan can be adjusted if needed.

How do you and your care team balance your outcomes and service costs?

The MCO is responsible for helping you to achieve your long-term care outcomes, but also has to consider cost when deciding what services to provide. Most MCOs do this through the RAD (Resource Allocation Decision) process.

The RAD process is a series of questions you and your care team will talk through to explore what you need and the options available to support your long-term care outcomes. This includes finding ways your friends, family or other community and volunteer organizations may help you, or ways you can do more for yourself. The RAD process also helps talk about how you would like to be involved in directing your care and services.

You have the right to know and understand all options, including how much things cost. Your responsibility is to talk with your team about these options so you can make

decisions together. This includes asking questions and sharing your opinions.

What if you and your care team cannot agree on a member-centered plan?

You and your care team may not always be able to agree about which service will be most effective or cost-effective. You and your care team should use the RAD process to examine the main issues and talk through your preferences and the different options.

If you are dissatisfied or do not agree with the services in your care plan, Family Care and Partnership provides you with three ways to file a grievance or appeal. See the section, “What choices do you have if you want to file a grievance or appeal?”

How do Family Care and Partnership help you control your own services?

Family Care and Partnership strive to respect the choices of their members. For example:

- Living arrangement, daily routine and support services of your choice are examples of the general outcome categories Family Care and Partnership support. You have a right to define what is important to you in these specific outcome areas. You will work with your care team to find reasonable ways to support these outcomes. If you do not think your care plan offers reasonable supports for your outcomes, then you can file a grievance or appeal.
- If you ask, the MCO must consider using a provider it does not usually use, if that provider would better meet your needs.
- For hands-on care or services that involve coming into your home often, the MCO will – upon your

request – buy services from a provider you choose, including a family member. The provider or family member must meet the MCO's requirements and agree to work at a cost similar to other providers.

- You have a right to change to a different care team, up to two times per year, if the MCO has a different care team to offer you. The MCO does not have to give you the particular care team you prefer.
- You may choose to self-direct one or more of your services. (See next section.)

What is Self-Directed Supports?

You can choose the self-directed supports (SDS) option if you want to manage some of your own services. SDS gives you considerable choice and control over:

- **Who** provides your services (such as a family member, friend or agency);
- **What** services you need;

- **How** you want your caregivers to do specific tasks; and
- **When** you receive services.

With SDS, you may have control over and responsibility for your own budget for services. You may also have control over your providers, including responsibility for hiring, training, supervising and firing your own direct care workers.

Though frequently used for in-home care, SDS can also be used outside of the home for services such as transportation and personal care at your work place. You can choose to self-direct one or more of your services. For example, you could choose to self-direct services that help you stay in your home or help you find and keep a job, and use your care team to manage services aimed at other outcomes in your plan. Your care team can tell you which services may be self-directed in Family Care and Partnership.

ADRCs tell people about the SDS option before they decide to enroll in Family Care or Partnership. Once you enroll, you will learn more about SDS when you meet with your care team.

What happens if you choose SDS?

The MCO will make resources available to find and pay for the services you need. You will work with your care team to establish a budget. After your care team approves your plan for using your SDS budget, then you can use that budget amount to buy the services that are:

- Effective in supporting your needs and outcomes;
- Included in your member-centered plan; and
- Eligible for self-direction.

If you choose the SDS option, your care team will meet with you to answer the following important questions:

- What service do you want to self-direct and how much do you want to participate in self-directing that service?
- What will your budget be for self-directed services/supports?
- How much responsibility do you want in managing your own budget – and what type of supports would you like? MCOs have contracted fiscal agents and co-employment agencies that can help you.
- Do you think you will need training or other resources to fully participate in SDS the way you would like?
- Who do you want to provide your services and supports?
- Do you have family, friends, or others who you would like to help you with participating in SDS?
- Are there any health and safety issues that should be addressed in your SDS plan? If so, do you have

ideas for how to deal with them? For instance, you will want to have a back-up plan if your personal care provider is unavailable.

It is helpful to think about these questions and discuss them with friends or family before meeting with your care team. The answers to these questions will be written clearly in your member-centered plan. The MCO must give you a copy of your plan.

Can you get help to participate in SDS?

Choosing SDS does not mean you are left on your own to do everything. There are a variety of supports available to you, including:

- Your care team can help you with a variety of activities – for example, creating a budget, developing a back-up plan and finding needed resources.

- Fiscal agents are available to help with payroll functions – for example, writing checks and taking out tax deductions.
- Co-employment agencies can help with payroll and other things as well – for example, writing a job description, and recruiting and training workers.

What if SDS is not working for you?

You can stop participating in SDS at any time, and your care team will take care of managing your care plan. If you want to make a change, then just talk to your care team. You can also work with your care team to find ways to make SDS work better for you.

Can the MCO limit your participation in SDS?

MCO care teams are responsible for your health and safety, and ensuring that funds are being used responsibly. The MCO may limit your participation in SDS if it finds that:

- You are not staying within your set plan and budget.
- You are using resources in a way that is illegal.
- Your health and safety or another person's health and safety is threatened.
- Someone else is making decisions for you that are not based on what you want.

If the MCO limits your participation in SDS, then the MCO must tell you how to file a grievance or appeal.

How can you learn more about SDS?

There are many ways to find out more about SDS, including:

- Talking to your care team;
- Talking to other members who have participated in SDS; and

- Looking at the SDS information on the Waisman Center's SDS Resource eLibrary (<http://cow.waisman.wisc.edu/sdswi.html>).

This website provides SDS information and resources for providers, consumers, guardians, families and friends.

How will you know about Family Care or Partnership decisions?

If your care team decides to deny, reduce or stop a service you have been receiving, then the MCO must send you a notice that tells you when the change will take effect and explains the reason for the decision. The notice will tell you how to file an appeal when you disagree with the decision.

If the MCO plans to stop or reduce a service that you are currently getting, and you appeal on or before the day the change will take effect, then you can ask to have the service continue during your appeal. However, you may

have to pay back the cost of the continued service if you lose your appeal.

At least once a year, an Income Maintenance worker, will review your financial eligibility and cost share. If there is a change in eligibility or cost share, then you will get a notice. You can also file an appeal or ask for a state fair hearing if you think the change is wrong.

What choices do you have if you want to file a grievance or appeal?

Family Care and Partnership give you several choices when you have a concern about your services. Your family, a friend, or a provider may file an appeal or grievance on your behalf when they have your permission or your guardian's permission. You can:

- File a grievance or appeal with the MCO.
- Ask for a review by the Wisconsin Department of Health Services (DHS), which is the agency that oversees Family Care and Partnership MCOs.

- Ask for a state fair hearing.

You can file a grievance with your MCO at any time. You must file an appeal, a request for DHS review or a request for fair hearing within 45 days from the date of the action or incident being appealed. Within that timeframe, you can choose to use any or all of the three ways listed above to file an appeal. You can use these methods together or at different times.

The appeal and grievance procedures are detailed in the Member Handbook/Evidence of Coverage. The MCO, its providers, or DHS are not permitted to treat you differently because you filed an appeal, grievance, or requested a fair hearing.

How do you file a grievance or appeal with the MCO?

To file a grievance or appeal with your MCO, you can either speak directly with a member of your care team or contact the MCO person identified in your Member

Handbook/Evidence of Coverage whose job it is to help you with grievances and appeals.

How do you request a review by the Department of Health Services?

To request a review by DHS, contact the Family Care and Partnership Grievance hotline by writing, calling or e-mailing:

DHS Family Care and Partnership Grievances

c/o MetaStar

2909 Landmark Place

Madison, WI 53713

Phone: (888) 203-8338 (HOTLINE)

Fax: (608) 274-8340

E-Mail: dhsfamcare@wisconsin.gov

You will be notified in writing within five days that your request has been received, and someone will be in touch with you to help you resolve the situation.

You will be asked whether you have already used the MCO's grievance or appeal process or requested a fair hearing to try to resolve your issue. Concerns can often be resolved directly with the MCO, before asking the State to review the situation. Using the MCO's grievance or appeal process first is not a requirement, but it is encouraged.

How do you request a fair hearing?

You can ask your MCO to help you file a fair hearing request, or you can make a request directly to the Division of Hearings and Appeals. Requests for a fair hearing must be made in writing. To file a request for a fair hearing you can either:

- Submit a Fair Hearing Request form (F-00236).
You can ask your MCO for the hearing form or go online and get the form at www.dhs.wisconsin.gov/forms/f0/f00236.doc; or
- Submit a written request to the following address with: your name, mailing address, a brief

description of the problem, a copy of the notice from the MCO, which county or MCO took the action or denied the service and your signature.

Family Care and Partnership Request for Fair Hearing

Division of Hearings and Appeals

P.O. Box 7875

Madison, WI 53707-7875

Phone: (608) 266-3096

TTY: (608) 264-9853

Fax: (608) 264-9885

<http://dha.state.wi.us>

Is there anyone at your MCO to help you with a grievance?

Each MCO has someone whose job it is to help members with grievances and appeals. The staff position and phone number of the person at your MCO who can help you are listed in your Member Handbook/Evidence of Coverage

and there is also contact information on the Family Care web site: www.dhs.wisconsin.gov/LTCare/help.htm.

What are some places outside of the MCO where you can get help?

An advocate is someone who helps you make sure the MCO is addressing your needs and outcomes. You can ask anyone you want to act as an advocate for you, including family members or friends.

Some other places you may get help are listed on the following pages.

Aging and Disability Resource Centers

You probably already met with a counselor at the Aging and Disability Resource Center (ADRC) who helped you to learn about your long-term care program options. The ADRC counselor also determined whether you are eligible for the program based on your financial situation and the amount of care and support you need.

If you are thinking of disenrolling from Family Care or Partnership, you will need to talk to the ADRC about other options for getting long-term care services, and to process the disenrollment.

ADRCs also provide information and assistance to:

- People who are in nursing homes or other institutions and want to live in the community;
- People experiencing abuse or neglect; and
- People who live in the community who are at risk of going into an institution because they cannot get the services and supports they need to remain in the community.

The ADRC can also tell you about other people or organizations that can help you, or be an advocate for you. Some of these are listed on the following pages. Your Member Handbook/Evidence of Coverage also includes a list of advocates. Ask your ADRC for more information about them.

Disability Benefit Specialists are on staff at each of the ADRCs and work with people ages 18-59 with physical or intellectual/developmental disabilities. A Disability Benefit Specialist provides assistance on application and eligibility issues for a broad range of public and private benefits and programs. A Disability Benefit Specialist is also available to provide information on the MCO's internal grievance procedure and state-level appeal options.

Elderly Benefit Specialists are people trained to help older persons who are having a problem with their private or government benefits. They can also help MCO members age 60 and over by providing information on the MCO's internal grievance procedure and state-level appeal options. You can contact the ADRC to get in touch with an Elderly Benefit Specialist.

Ombudsman Programs

Regional Ombudsmen are available to respond to your concerns in a timely fashion. The ombudsman programs will typically use informal negotiations to resolve your

issues without a formal grievance or state fair hearing process.

- **Disability Rights Wisconsin (DRW)**
Ombudsmen from this agency provide advocacy to Family Care and Partnership members under age 60.

Disability Rights Wisconsin

131 W. Wilson St., Suite 700

Madison, WI 53703

608-267-0214

TTY: 888-758-6049

Fax: 608-267-0368

Madison Toll-free: 800-928-8778

Milwaukee Toll-free: 800-708-3034

Rice Lake Toll-free: 877-338-3724

www.disabilityrightswi.org (includes contact information for all three offices)

- **Wisconsin Board on Aging and Long Term Care**
Ombudsmen from this agency provide advocacy to

Family Care and Partnership members age 60 and older.

Board on Aging and Long Term Care

1402 Pankratz Street, Suite 111

Madison, WI 53704

Toll-free: 800-815-0015

Fax: 608-246-7001

<http://longtermcare.state.wi.us>

Independent Living Centers (ILCs) are consumer-directed, non-profit organizations that provide an array of services, including peer support, information and referral, independent living skills training, advocacy, community education, personal care and service coordination. To find an ILC in your area, go to

www.dhs.wisconsin.gov/Disabilities/Physical/ILCs.htm.

Glossary of Terms

ADRC (Aging and Disability Resource Center) – the first place to go with your aging and disability questions.

ADRCs are service centers that provide a place for the public to get accurate, unbiased information on all aspects of life related to aging or living with a disability.

Appeal – a request for review of an action taken by an MCO.

Department of Health Services (DHS) – the State agency that contracts with the MCO for Family Care and Partnership services.

Community Supports – supports and services that the MCO does not authorize or pay for, and that are available to the general population. This includes libraries, churches, senior centers, and classes and activities at local community centers.

Comprehensive Assessment (assessment) – the process the care team uses to have a clear understanding of the member and the services and items necessary to support the member's needs, including personal and long-term care outcomes and preferences. The comprehensive

assessment is completed within 90 days from the enrollment date.

Cost-effective – the option that effectively supports an identified long-term care outcome at a reasonable cost and effort.

Cost-share (Spend down) – the money a member may be required to pay in order to be eligible for the services he or she receives. This is determined by the Income Maintenance agency.

Fair Hearing – a hearing held by an Administrative Law Judge who works for the State of Wisconsin Division of Hearings and Appeals. This Division is independent of both the MCO and DHS.

Grievance – an expression of dissatisfaction about care, services or other general matters, such as quality of care or relationships with the member's care team.

Family Care – a comprehensive and flexible long-term care service system. Family Care strives to foster people's

independence and quality of life, while recognizing the need for interdependence and support.

Family Care Partnership (Partnership) – formerly known as Wisconsin Partnership Program, integrates health and long-term support services.

Interdisciplinary Team (Care Team) – referred to as your “care team” in this booklet. The interdisciplinary team, which includes the member, defines the member’s outcomes and creates the member-centered plan.

Long-Term Care Outcomes – a situation, condition or circumstance, that a member or care team identifies that maximizes a member’s highest level of independence. A long-term care outcome is based on the member’s assessed clinical and functional needs.

Managed Care Organization (MCO) – an organization that operates Family Care and/or Partnership long-term care programs.

Member – a person who is enrolled in Family Care or Partnership.

Member-Centered Plan (MCP) – a care plan that documents a process by which the member and the care team further identify, define and prioritize the member's outcomes. The MCP includes how friends, family and community resources, and MCO services and supports will be used to support the member's outcomes. The MCP is completed and signed by the member within 90 days from enrollment.

Natural Support – the member's social network of family, friends, and neighbors that may be available to provide assistance to the member.

Ombudsman – a person who investigates reported concerns and helps members resolve issues. Disability Rights Wisconsin provides ombudsman services to potential and current Family Care and Partnership members under age 60. The Board on Aging and Long

Term Care provides ombudsman services to potential and current members age 60 and older.

Personal Experience Outcomes – represent what is important to the member, or are things the member wishes were different in his or her life.

Resource Allocation Decision (RAD) – a step-by-step tool you and your care team will use to help determine the most effective and cost-effective way to achieve your long-term care outcomes.

Self-Directed Supports (SDS) – an option in Family Care and Partnership that gives you considerable choice over how support services are provided and by whom.

Goals of Family Care and Partnership:

CHOICE – Give people better choices about the services and supports available to meet their needs.

ACCESS – Improve access to services.

QUALITY – Improve quality through a focus on health and social outcomes.

COST-EFFECTIVE – Create a cost-effective long-term care system for the future.

Family Care and/or Partnership
long-term care programs are currently available in most
Wisconsin counties.

As a comprehensive and flexible long-term care service
system, Family Care and Partnership strive to foster
members' independence and quality of life, while
recognizing the need for interdependence and support.

This booklet is also available in
Spanish, Hmong,
Russian, and Braille.



Wisconsin Department of Health Services
Division of Long Term Care
Office of Family Care Expansion
P.O. Box 7851
Madison, Wisconsin 53707-7851
www.dhs.wisconsin.gov/LTCare