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| **DEPARTMENT OF HEALTH SERVICES**  Division of Medicaid Services  F-01209 (02/2017) | | **STATE OF WISCONSIN** |
| **IRIS Certification Acknowledgement** | | |
| **INSTRUCTIONS:** | Completion of this form is not required through Wisconsin State Statute; however, completion of this form is an IRIS Program requirement. | |
| Employees**:** | Review, sign and return this form to your supervisor. Your supervisor will forward to the Department as condition of your agency’s meeting the IRIS Certification Criteria. | |
| Supervisors: | Submit this form to the contract administrator. | |
| Employee – Name (Print or Type) | | Certified Agency |
| I acknowledge that I have received electronic access or hard copy access to the following documents. I further acknowledge: | | |
| I have reviewed the IRIS 1915(c) Home and Community Based Services Waiver. | | |
| I have reviewed the IRIS Policy and Procedure Manual ([P-00708](http://www.dhs.wisconsin.gov/publications/P0/P00708.pdf)). | | |
| I have reviewed the IRIS Service Code Definition Manual. | | |
| I have reviewed, understand and have signed the IRIS Conflict of Interest Disclosure Statement ([F-01310](http://www.dhs.wisconsin.gov/forms/F0/F01310.docx)) | | |
| I have completed required HIPAA training, and understand that I must complete this training annually. | | |
| ­**SIGNATURE** –Employee | | Date Signed |
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