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| **STATE OF WISCONSIN**  **DEPARTMENT OF HEALTH SERVICES**  Division of Public Health  F-00075 (02/2024) |  | | **CIP** |
| **IRIS (include, respect, I self-Direct) authorization** | | | |
| Completing and signing this form is voluntary; however, no referral to enroll or transfer within the IRIS Program can be processed without the completed signed form. If you want to apply for this program, you must contact your local aging and disability resource center (ADRC) or your Tribal Aging and Disability Resource Specialist (ADRS). Contact information for local ADRCs or Tribal ADRS can be found at [www.dhs.wisconsin.gov/adrc/consumer/index.htm](http://www.dhs.wisconsin.gov/adrc/consumer/index.htm).  The IRIS Authorization form (F‑00075) has multiple functions and must accompany all referrals to enroll or transfer within the IRIS Program. All information entered must be complete and accurate. Your signature or the signature of your legal guardian, conservator, or your activated power of attorney is required. If you sign with a mark, two witness signatures are required. If you are physically unable to sign, you may direct an adult to sign the form in front of two witnesses. The person who signs on your behalf should indicate that they are signing at the direction of the applicant.  Aging and Disability Resource Center (ADRC) or Tribal Aging and Disability Resource Specialist (ADRS) staff complete and submit the form to the IRIS consultant agency (ICA). The ADRC or Tribal ADRS must retain the originally signed IRIS Authorization Form or an electronically scanned copy of the signed form for ten years in the event of a records request. | | | |
| **I. REFERRAL INFORMATION—** The referral agent (ADRC or Tribal ADRS) completes **all** boxes in this section. | | | | |
| Date – ICA granted read only access to LTCFS | | Date – Referral to ICA | | |
| **Participant Information** | | | | |

| Name (Last, First, MI) | | | | | | | | | | | | | Date of Birth | | | | County of Residence | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Native American/Alaskan Native  Yes  No | | | | | | | | | | | | | Native American/Alaskan Native Affiliation: | | | | | | | |
| Address | | | | | | | | | | | | | City | | | | | | Zip Code | |
| Phone Number | | | Email Address | | | | | | | | | | | | | | | Best Time to Contact | | |
| Established Guardianship  Yes  No | | | Activated Power of Attorney for Health Care  Yes  No | | | | | | | | | | | | Activated Power of Attorney for Finance  Yes  No | | | | | |
| Name – Guardian / POA Contact | | | | | | | | | | | | | | | | | | | | |
| Phone Number – Guardian / POA | | | | | | | | | | | | | | Best Time to Contact | | | | | | |
| Medicaid Eligibility Established (initial referral only)  Yes  No  Medicaid Pending | | | | | | | | | | | | | | Medicaid ID No: | | | | | | |
| Medicare or Other Insurance (initial referral only)  Yes  No | | | | | | | | | | | | | | Language for CARES Notice:  English  Spanish | | | | | | |
| Beneficiary Name (First, MI, Last) | | | | | | | | Medicare Beneficiary Identifier (MBI) | | | | | | | | | | | | |
| Monthly Cost Share Amount (initial referral only) | | | | | | | | | | | | | | | | | | | | |
| $ |  | | (enter 0 if no cost share) | | | | | | | | | | | | | | | | | |
| SSI-E (initial referral only) | | | | | | | | | | | | | | | | | | | | |
| Receiving  Not Eligible  Declined | | | | | | | | | | | | | | | | | | | | |
| Person is currently enrolled in (check only one) | | | | | | | | | | | | | | | | | | | | |
| No Prior Program | | | | HMO Managed Care | | | | | | | | | | | | | | | | |
| Family Care / PACE/Partnership MCO—Specify MCO Name: | | | | | | | | | | | | | | | | | | | | |
| IRIS—Specify ICA Name: | | | | | | |  | | | | | | | | | | | | | |
| Children’s Waiver (CLTS) Please complete contact information below. | | | | | | | | | | | | | | | | | | | | |
| Name – CLTS Worker | | | | | | | | | | | | | | | | County | | | | |
| Phone Number | | | | | | Email Address | | | | | | | | | | | | | | |
| **Other Pertinent Information** (Check all that apply) | | | | | | | | | | | | | | | | | | | | |
| In need of Immediate Services | | | | | | | | | | | Has a Protective Placement | | | | | | | | | |
| Currently served by CSP | | | | | | | | | | | Relocation / Currently living in non-allowable setting (NH, IMD, CBRF, etc.) | | | | | | | | | |
| Language Interpreter Needed | | | | | | | | | | | | | | | | | | | | |
| Other—Specify: | | | | | | | | | | | | | | | | | | | | |
| Level Of Care  Check the assigned NH LOC in the left column and then check the appropriate DD LOC in the right column. A maximum of two boxes should be checked.   |  |  | | --- | --- | | Choose 1 | Choose 1 | | NH-ISN  NH-SNF  NH-ICF | DD1A  DD1B  DD2  DD3  NDD | |  |  | | | | | | | | | | | | | Target Group:  FE  ID/DD  PD | | | | | | | | |
| Name of Selected ICA | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| Name of Selected FEA (only applies to initial IRIS referral and selection) | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| I am interested in considering becoming an IRIS Waiver participant. I understand I will have the opportunity to meet with a consultant from IRIS who will provide me with additional information about IRIS.  I understand that a referral to the IRIS consultant agency is not a commitment to enroll in the IRIS program.  I or my representative may withdraw from IRIS at any time upon request.  I understand that if I am dissatisfied with the ICA that I have selected, I may choose another ICA.  I understand that the Fiscal Employer Agent I have selected will be responsible for providing payment to all waiver service providers.  I understand that if I am dissatisfied with the FEA that I have selected, I may choose another FEA during the allowable transfer period.  I authorize that the above selected IRIS consultant agency be given access to the following information to help me enroll in IRIS:   * Access to my Long-Term Care Functional Screen (LTCFS) information * Copy of my CARES Medicaid verification or budget sheets (identifies cost share and financial eligibility) * Medical remedial expense details (if applicable) * Current copy of my Individual Support and Service Plan (ISSP) / Member Centered Plan (MCP) (if applicable and available) * Medical documentation * Other – Specify: | | | | | | | | | | | | | | | | | | | | |
| **Signing this form does not guarantee eligibility for the IRIS Program or the ability to transfer between ICAs.** | | | | | | | | | | | | | | | | | | | | |
| **SIGNATURE** – Applicant | | | | | | | | | | | | | | | | | | | | Date Signed |
|  | | | | | | | | | | | | | | | | | | | |  |
| **SIGNATURE** – Legal Guardian, Conservator, or Activated Power of Attorney | | | | | | | | | | | | | | | | | | | | Date Signed |
|  | | | | | | | | | | | | | | | | | | | |  |
| **SIGNATURE** – Legal Guardian, Conservator, or Activated Power of Attorney | | | | | | | | | | | | | | | | | | | | Date Signed |
|  | | | | | | | | | | | | | | | | | | | |  |
| **SIGNATURE** – Witness (if applicable) | | | | | | | | | | | | | | | | | | | | Date Signed |
|  | | | | | | | | | | | | | | | | | | | |  |
| **SIGNATURE** – Witness (if applicable) | | | | | | | | | | | | | | | | | | | | Date Signed |
|  | | | | | | | | | | | | | | | | | | | |  |
| **III. INFORMATION COMPLETED BY** | | | | | | | | | | | | | | | | | | | | |
| Name – ADRC or Tribe | | | | | | | | | | | | | | | | | | | | |
| Name – ADRC or Tribal ADRS Worker | | | | | | | | | | | | | | | | County | | | | |
| Phone Number | | | | | | Email Address | | | | | | | | | | | | | | |
| Distribution of completed form: | | | | | Individual, Guardian, Conservator, or Activated Power of Attorney  Selected ICA  Tribe if applicable  CLTS Worker if applicable | | | | | | | | | | | | | | | |
| **IV. IRIS REFERRAL BACK TO ADRC or Tribal ADRS and IM and CLTS Worker if applicable.** | | | | | | | | | | | | | | | | | | | | |
| Name – ICA | | | | | | | | | Name – Staff Person | | | | | | | | | | Date | |
| IRIS Start Date | | | | | | | | | | | | | | | | | | | | |
| Customer requested withdrawal | | | | | | | | | | IRIS Program Requested Withdrawal | | | | | | | | | | |
| ICA Transfer Denied | | | | | | | | | | | | | | | | | | | | |
| Reason: | |  | | | | | | | | | | | | | | | | | | |