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| **DEPARTMENT OF HEALTH SERVICES**  Division of Medicaid Services  F-01210 (12/2017) | | | | | | | |  | | | | **STATE OF WISCONSIN** | | | | | | |
| **IRIS BUDGET AMENDMENT REQUEST** | | | | | | | | | | | | | | | | | | |
| **INSTRUCTIONS:** | Completion of this form is not required through Wisconsin State Statute; however, completion of this form is an IRIS program requirement. Personally identifiable information on this form is collected to verify that the request is complete, and will be used only for this purpose.  See page 3 of this form for detailed instructions. | | | | | | | | | | | | | | | | | |
| **SECTION I – DEMOGRAPHICS (ALL FIELDS MUST BE FILLED)** | | | | | | | | | | | | | | |
| Participant’s Name (Last, First) | | | | | | | | Participant’s MCI Number | | | | | | | | | | |
| County of Residence | | | | | | | | Date of Birth | | | | | | | | | | |
| Target Group | | | | | | | | IRIS Consultant | | | | | | | | | | |
| Anticipated Review Date | | | | | | | | Date Participant Identified Need | | | | | | | | | | |
| SharePoint Issue ID Number | | | | | | | | IRIS Start Date | | | | | | | | | | |
| Total Number of Care Hours per Day (Current) | | | | | | | | Total Number of Care Hours per Day (Proposed) | | | | | | | | | | |
| **SECTION II – CURRENT SUPPORTS/SERVICES/GOODS (FUNDED BY IRIS)** | | | | | | | | | | | | | | |
| **Supports/Service/Good** | | **Previously Approved Budget Amendment or One-Time Expense** | | **Vendor/Provider** | | **Units Per Week** | | | **Rate Per Unit**  **(without and with taxes)** | | **Total Weekly Service Amount** | | | **Total Monthly Service Amount** | | | | **Variance in Actual Spend Plan Year to Date** |
|  | | Yes  No | |  | |  | | |  | |  | | |  | | | |  |
|  | | Yes  No | |  | |  | | |  | |  | | |  | | | |  |
|  | | Yes  No | |  | |  | | |  | |  | | |  | | | |  |
|  | | Yes  No | |  | |  | | |  | |  | | |  | | | |  |
|  | | Yes  No | |  | |  | | |  | |  | | |  | | | |  |
|  | | Yes  No | |  | |  | | |  | |  | | |  | | | |  |
|  | | Yes  No | |  | |  | | |  | |  | | |  | | | |  |
|  | | Yes  No | |  | |  | | |  | |  | | |  | | | |  |
|  | | Yes  No | |  | |  | | |  | |  | | |  | | | |  |
|  | | Yes  No | |  | |  | | |  | |  | | |  | | | |  |
| **TOTAL:** | | | | | | | | | | | | | |  | | | |  |
| **SECTION III – CURRENT SUPPORTS/SERVICES/GOODS (FUNDED BY NON-IRIS FUNDING SOURCES)** | | | | | | | | | | | | | | | | |
| **Supports/Service/Good** | | | **Funding Source** | | **Vendor/Provider** | | **Units per Week** | | | **Rate per Unit (including taxes)** | | | **Total Weekly Service Amount** | | | **Total Monthly Service Amount** | | |
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| **SECTION IV – REQUESTED IRIS FUNDED SUPPORT/SERVICE/GOOD** | | | | | | | | | | | | | | | | | | |
| **Support/Service/Good** | | | **Vendor/Provider** | | | | | **Units Per Week** | | | | | **Rate Per Unit**  **(without and with taxes)** | | | | | | | | | **Total Weekly Cost of Budget Amendment** | | | | | **Total Monthly Cost of Budget Amendment** | | | | | | | | |
|  | | |  | | | | |  | | | | |  | | | | | | | | |  | | | | |  | | | | | | | | |
| **SECTION V – JUSTIFICATON** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1 | Identify the long-term care outcome that the requested support/service/good will help the participant achieve. | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
| 2 | Explain how the requested support/service/good will help the participant achieve the long term care outcome identified in question 1. | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
| 3 | Why is the support/service/good needed? | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
| 4 | What steps have been taken to meet the participant’s needs within the existing budget? | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
| 5 | Explain how the budget amendment helps the participant improve or maintain ability. | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
| 6 | Explain how the budget amendment will prevent/resolve a health/safety risk. | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
| 7 | Describe the participant’s living situation. | | | | | | | | | | Lives Alone  Lives with others        Number of people in residence (including participant) | | | | | | | | | | | | | Rents  Owns  House  Apartment  Condo  Trailer  AFH 1-2 | | | | | | | | AFH 3-4  RCAC  CBRF  Shelter  Vehicle  RV | | | |
| 8 | Describe how SHC hours are utilized when multiple people live in the same household to ensure that the DHS Caregiver Assurances Policy is met. See IRIS Policy Manual Section 5.5 for more information on the policy. | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
| 9 | Describe the participant’s employment status. | | | | | | | | | | Full-Time  Part-Time  Does not work, but is interested in employment  Does not work, is not interested in employment | | | | | | | | | Integrated community setting  Facility-based setting | | | | | | | | Type of Work: | | | | | | | |
| Employer: | | | | | | | | Hours per week: | | | | | | | |
| Wage: | | | | | | | | Support Utilized:  Yes  No | | | | | | | |
| 10 | Comparison of actual SHC hours on plan vs. hours recommended by the Home and Community Support Assessment vs. hours requested. | | | | | | | | | | Actual SHC Hours on plan: | | | | | | | | | Recommended number of hours on Home and Community Support Assessment: | | | | | | | | Additional SHC Hours requested: | | | | | | | |
| 11 | Justification of hours on current plan above what is recommended by the Home and Community Support Assessment. | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
| 12 | Describe the participant’s involvement in the community. | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
| 13 | Describe the natural supports available to the participant. | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
| 14 | Describe how it was determined that the budget amendment request was the most cost-effective strategy. | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
| 15 | If the participant is currently overspending their existing budget, explain why. | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
| Name of ICA Staff | | | | | | | | | | | | | | | Email | | | | | | | | | | | | | | | | | | | | |
| By completing and submitting this form, you are confirming that you have completed all required fields. You further confirm that all information provided has been reviewed, verified and is accurate to the best of your knowledge. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **INSTRUCTIONS FOR COMPLETING THE IRIS BUDGET AMENDMENT REQUEST** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Who Should Use This Form**  This form should be used by IRIS consultant agencies serving participants who request a budget amendment. All relevant attachments should be submitted with this form. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **How to Complete This Form**  This form is to be completed and submitted electronically. This document is a fillable Microsoft Word document. TAB or CLICK between fields. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| \*\*ALL FIELDS ON THIS FORM ARE REQUIRED. AN INCOMPLETE FORM WILL RESULT IN PROCESSING DELAYS\*\* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Section I – DEMOGRAPHICS:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Participant’s Name**: Insert Participant’s Name | | | | | | | | | | | | | | | | | **MCI**: Insert Participant’s MCI | | | | | | | | | | | | | | | | | |
| **County of Residence**: Insert Participant’s County of Residence | | | | | | | | | | | | | | | | | **Date of Birth**: Insert Participant’s Date of Birth | | | | | | | | | | | | | | | | | |
| **Target Group**: Insert Participant’s Target Group | | | | | | | | | | | | | | | | | **IRIS Consultant**: Insert Name of Participant’s Consultant | | | | | | | | | | | | | | | | | |
| **Anticipated Review Date**: Insert the date the ICA anticipates that DHS will review the request. The Department will review the one-time expense or budget amendment request on the Monday after the request is received via SharePoint with the Wednesday before the review being the cutoff. Ex. For reviews taking place on Monday, January 27, the cutoff would be noon on Wednesday, January 22. Any requests received on Thursday, January 23 would be reviewed on Monday, February 3. | | | | | | | | | | | | | | | | | **Date Participant Identified Need**: Insert the date the participant first informed the consultant of the needed budget amendment. | | | | | | | | | | | | | | | | | |
| **SharePoint Issue ID number**: Enter the number of the Issue ID in SharePoint (Column 1) | | | | | | | | | | | | | | | | | **IRIS Start Date**: Enter the participant’s start date in the IRIS program. | | | | | | | | | | | | | | | | | |
| **Total Number of Care Hours per Day (current)**: Insert the average number of care hours budgeted in the current plan. This should be calculated by adding all care hours (SHC, IRIS SDPC/MAPC, Respite, Adult Day Care, Adult Day Services, Prevocational Services, Supported Employment, etc.) and divide the total by 30.4. | | | | | | | | | | | | | | | | | **Total Number of Care Hours per Day (proposed):** Insert the average number of care hours proposed through this budget amendment. This should be the total number of hours requested through the new request by adding the additional hours and dividing by 30.4. | | | | | | | | | | | | | | | | | |
| **SECTION II – CURRENT SUPPORTS/SERVICES/GOODS (FUNDED BY IRIS)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Supports/Service/Good** | | **Previously Approved Budget Amendment or One-Time Expense** | | | | **Vendor/ Provider** | | | **Units per Week** | | | | | **Rate per Unit**  **(without and with taxes)** | | | | | | | **Total Weekly Service Amount** | | | | | **Total Monthly Service Amount** | | | | | | | | **Variance in Actual Spend Plan Year to Date** |
| Enter the Medicaid Waiver approved support/service/ good currently on the approved plan.  You may add additional rows to this section if necessary to accommodate all goods/services/ supports on current approved plan. | | Yes  No  Check yes or no with the applicable answer. | | | | Enter the name of the provider or vendor providing the service/support/ good. Specific names are required. If there are multiple providers, list ALL providers. | | | Enter the number of units per week on the current approved plan. | | | | | Enter the rate per unit and the unit of measurement  Ex. Per mile, per hour, per day, per week, per trip, etc.  Hourly rates provided must be written without and with taxes. | | | | | | | Enter the total weekly service amount on approved current plan. This should be taken from the plan or otherwise calculate as units per week x rate per unit. | | | | | Enter the total monthly service amount on the approved current plan. This should be taken from the plan or otherwise calculated as the total weekly service amount x 53, and divided by 12. | | | | | | | | Enter the variance in the actual spend for the plan year to date. This information should be taken from the financial data source. All numbers indicating spending within budget should be in green. All numbers indicative of overspending should be in parentheses and in red. |
| **TOTAL:** | | | | | | | | | | | | | | | | | | | | | | | **Enter the total monthly service amount on the plan. This should equal the total of all other line items in this column.** | | | | | | | All numbers indicating spending within budget should be in green. All numbers indicative of overspending should be in parentheses and in red. | | | | |
| **SECTION III – CURRENT SUPPORTS/SERVICES/GOODS (FUNDED BY NON-IRIS FUNDING SOURCES)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Supports/Service/Good** | | | | **Funding Source** | | | **Vendor/ Provider** | | | | | **Units per Week** | | | | | | **Rate per Unit (including taxes)** | | | | | | | **Total Weekly Service Amount** | | | | **Total Monthly Service Amount** | | | | | |
| Enter the support/service/ good currently on the plan that is funded by a source other than IRIS.  All MA card services and natural supports should be documented here as well.  You may add additional rows to this section if necessary to accommodate all goods/services/supports on current approved plan | | | | Enter the non-IRIS funding source. IRIS SDPC should be entered as the funding source for IRIS SDPC. | | | Enter the name of the provider or vendor providing the service/support/ good. Specific names are required. If there are multiple providers, list ALL providers | | | | | Enter the number of units per week on the current approved plan | | | | | | Enter the rate per unit and the unit of measurement.  Ex. Per mile, per hour, per day, per week, per trip, etc.  Rate provided must include taxes. | | | | | | | Enter the total weekly service amount on the approved current plan. This should be taken from the plan or otherwise calculated as the units per week x rate per unit. | | | | Enter the total monthly service amount on the approved current plan. This should be taken from the plan or otherwise calculated as the total weekly service amount x 53, and divided by 12. | | | | | |
|  | | | | | | | | | | | | | | | | | | **TOTAL:** | | | | | | | **Enter the total monthly service amount of non-IRIS funded items on the plan. This should equal the total of all other line items in this column.** | | | | | | | | | |
| **SECTION IV – REQUESTED IRIS FUNDED SUPPORT/SERVICE/GOOD** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Support/Service/Good** | | | | | **Vendor/Provider** | | | | | **Units per Week (without and with taxes)** | | | | | | **Rate per Unit (without and with taxes)** | | | | | | | **Total Weekly Cost of Budget Amendment** | | | | | | | | **Total Monthly Cost of Budget Amendment** | | | |
| Enter the Medicaid Waiver approved support/service/ good that is being requested. This service MUST be an approved service/support/ good in the Medicaid Waiver.  **Only one support/service/ good may be requested per form. You may not add additional rows to this section and you may not combine multiple supports/services/goods into one line.** | | | | | Enter the name of the provider or vendor who will provide the service/support/ good. Specific names are required. If there are multiple providers, list ALL providers. If the name is unknown at the time of the request, document “unknown at this time” | | | | | Enter the number of units per week being requested.  Hourly rates provided must be written without and with taxes. | | | | | | Enter the rate per unit being requested. The ICA must include the unit of measurement  Ex. Per mile, hour, day, week, trip, etc.  Hourly rates provided must be written without and with taxes | | | | | | | Enter the total weekly cost of the requested budget amendment. This should be calculated through the units per week x rate per unit. | | | | | | | | Enter the total monthly cost of the requested budget amendment. This should be the calculated through the total weekly cost of budget amendment amount x 53, and divided by 12. | | | |
| **SECTION V – JUSTIFICATON** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1 | Identify the long term care outcome that the requested support/service/good will help the participant achieve. | | | | | | | | | | Identify the long-term care outcome on the participant’s plan that will be supported by the approval of the requested support/service/good. | | | | | | | | | | | | | | | | | | | | | | | |
| 2 | Explain how the requested support/service/good will help the participant achieve the long term care outcome identified in question 1. | | | | | | | | | | Provide an explanation of how the requested support/service/good will aid the participant in achieving the long-term care outcome identified in question 1. | | | | | | | | | | | | | | | | | | | | | | | |
| 3 | Why is the support/service/good needed? | | | | | | | | | | Explain what has changed with the participant’s situation to justify the new service/support/good or increase in services/supports/goods. This section should also explain whether or not the requested support/service is a new support or if it is replacing natural support. | | | | | | | | | | | | | | | | | | | | | | | |
| 4 | What steps have been taken to meet the participant’s needs within the existing budget? | | | | | | | | | | Explain what other resources have been explored including MA Card Services, services that are funded by other sources such as DVR, natural supports, etc. | | | | | | | | | | | | | | | | | | | | | | | |

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| 5 | Explain how the budget amendment helps the participant improve or maintain ability. | Explain how the participant may improve or maintain their abilities through the addition of the services/supports/goods. Be specific about which of the participant’s abilities will benefit through the budget amendment and how. Include information about how in the future this may reduce the participant’s need for additional services/supports/goods. | | | | |
| 6 | Explain how the budget amendment will prevent/resolve a health/safety risk. | Explain how the addition of the services/supports/goods will prevent/resolve a health/safety risk. Be specific about what the health/safety risk is, how often it occurs, and the extent of the risk. | | | | |
| 7 | Describe the participant’s living situation. | Lives alone  Lives with others        Number of people in residence (including participant)  Check the appropriate box to indicate with whom the participant lives. If the participant lives with others, enter the number of people living in the residence.  Rents  Owns  Check the appropriate box to indicate whether or not the participant rents or owns their dwelling. | | House  Apartment  Condo  Trailer  AFH 1-2  AFH 3-4  CBRF  RCAC  Shelter  Vehicle  RV  Check the appropriate box to indicate the type of dwelling in which the participant resides. If a participant indicates that they live in an AFH, RCAC, or CBRF ensure that it is clearly explained how the budget amendment will assist them in transitioning to their own residence in the other fields. | | |
| 8 | Describe how SHC hours are utilized when multiple people live in the same household to ensure that the DHS Caregiver Assurances Policy is met. See IRIS Policy Manual Section 5.5 for more information on the policy. | Utilizing IRIS Policy Manual Section 5.5, describe how the SHC hours are utilized to ensure that IRIS funds are not being used to pay for shared household tasks in a shared household. \*\*NOTE: If it is discovered that SHC hours are being used to pay for shared tasks in a shared household, this MUST be rectified prior to submitting this budget amendment request to DHS for review. | | | | |
| 9 | Describe the participant’s employment status. | Full-Time  Part-Time  Does not work, but is interested in employment  Does not work, is not interested in employment  Check the appropriate box. | Integrated community setting  Facility-based setting  Check the appropriate box. | | Type of Work:  Enter the type of work the participant does: Ex. Receptionist, housekeeping, line cook, dishwasher, etc. | |
| Employer  Enter the participant’s employer. | | Hours per week  Enter the average number of hours/week the participant works. | |
| Wage  Enter the participant’s wage. | | Support Utilized:  Yes  No  Does the participant utilize a job coach or other support to work? This service should be captured in Section 2 if paid for with IRIS funds. | |
| 10 | Comparison of actual SHC hours on plan vs. hours recommended by the Home and Community Support Assessment vs. hours requested. | Actual SHC Hours on plan:  Enter the hours per day on the current approved plan. Take the monthly total and divide by 30.4 to get the daily average.  \*\*This is required regardless of what is being requested. | Recommended Number of hours on Home and Community Support Assessment:  Enter the number of hours per day recommended by the Home and Community Support Assessment.  \*\*This is required regardless of what is being requested. | | | Additional SHC Hours Requested:  Enter the number of hours per day of SHC being requested through the budget amendment request. |
| 11 | Justification of hours on current plan above what is recommended by the Home and Community Support Assessment. | Provide an explanation if the hours on the current plan are above what is recommended by the Home and Community Support Assessment. Situations that may be considered justified include extenuating circumstances such as seizure activity or behavioral needs that are not accounted for in the application of the Home and Community Support Assessment. | | | | |
| 12 | Describe the participant’s involvement in the community. | Explain what involvement the participant has in the community – church, Special Olympics, clubs, activities with friends/family, etc. | | | | |
| 13 | Describe the natural supports available to the participant. | Explain all supports the participant receives from unpaid supports that assist the participant in receiving needed care or being involved in the community. Include the relationship of the individuals providing (specific family, friend from church/work etc.), the type of support they provide, and the frequency of the support. | | | | |
| 14 | Describe how it was determined that the budget amendment request was the most cost-effective strategy. | Provide a comparative analysis of all options available to meet the same end result and describe how the service/support/good presented in the budget amendment requested was determined to be the most cost-effective. This section should also detail any reason why the cheapest provider was not chosen. | | | | |
| 15 | If the participant is currently overspending their existing budget, explain why. | Review the value entered in the column entitled “Variance in Actual Spend Plan Year to Date” in Section 2. If the value indicates underspending, enter “Not applicable – participant is spending within their budget.” If the value indicates overspending, provide an explanation as to why the overspending is occurring. | | | | |
| **Person Completing This Form**  The ICA staff that completes this form must also provide DHS with all relevant forms. When submitting this form, you are assuring that the information you provided has been verified and is accurate to the best of your knowledge. | | | | | | |
| **How to Submit This Form**  This form and any relevant accompanying forms should be attached electronically to the DHS Budget Amendment SharePoint site, in the appropriate participant’s file. | | | | | | |