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| **DEPARTMENT OF HEALTH SERVICES**  Division of Medicaid Services  F-01310 (02/2017) | | | **STATE OF WISCONSIN** |
| **IRIS PROGRAM CONFLICT OF INTEREST DISCLOSURE – PROVIDER** | | | |
| **INSTRUCTIONS** | | | |
| IRIS Consultant Agencies (ICAs) and Fiscal Employer Agents (FEAs) must disclose if an employee, or the immediate family member of an employee, owns or controls a ten percent or greater interest of a provider of Wisconsin Medicaid services in any Wisconsin Medicaid program.  IRIS Consultant Agencies and Fiscal Employer Agents must disclose if an employee, or the immediate family member of an employee, receives payment of more than three thousand dollars ($3,000) within a twelve (12) month period from any provider of Wisconsin Medicaid services in any Wisconsin Medicaid program.  “Immediate family” includes spouses, domestic partners, parents, children and siblings. If multiple family members meet the criteria, the employee must complete a separate form for each conflict identified.  Completion of this form is not required by Wisconsin State Statute, but is a requirement of ICA or FEA provider certification. Personally identifiable information on this form is collected to verify that the application is complete and accurate, and will be used only for this purpose. | | | |
| **EMPLOYEE** | | | |
| 1. | If you, or an immediate family member, do not own/control a 10% or greater interest of any provider of Wisconsin Medicaid Services in any Wisconsin Medicaid Program and do not receive payment of more than $3000 within a 12-month period from any provider of Wisconsin Medicaid Services in any Wisconsin Medicaid Program, check the ‘A’ box, sign and date the form, and return it to your supervisor. | | |
| 2. | If you, or an immediate family member, do own/control, or plan to own/control a 10% or greater interest of any provider of Wisconsin Medicaid Services in any Wisconsin Medicaid Program in the near future, check the ‘B’ box, sign and date the form, and return it to your supervisor. | | |
| 3. | If you, or an immediate family member, do receive payment, or plan to receive payment of more than $3000 within a 12-month period from any provider of Wisconsin Medicaid Services in any Wisconsin Medicaid Program in the near future, check the ‘C’ box, sign and date the form, and return it to your supervisor. | | |
| **SUPERVISOR** | | | |
| 1. | If box ‘A’ is checked, sign and date the form and send to the Department of Health Services – IRIS Section. | | |
| 2. | If box ‘B’ and/or box ‘C’ is checked, review the description of the conflict of interest and mitigation strategy sections, check the appropriate decision, add recommendations as appropriate, and sign and date the form. Send the completed form to the Department of Health Services – IRIS Section. | | |
| ICA or FEA Provider Name | | | Employee Home Address |
| Employee Name | | | Name of Individual with Conflict |
| Employee Title | | | Relationship of Individual with Conflict |
| **Check all that apply:** | | | |
| A. |  | By my signature below, I affirm neither I, nor any immediate family members, own/control a 10% or greater interest of any provider of Wisconsin Medicaid Services in any Wisconsin Medicaid Program and do not receive payment of more than $3000 within a 12-month period from any provider of Wisconsin Medicaid Services in any Wisconsin Medicaid Program. | |
| B. |  | By my signature below, I affirm I, or an immediate family member, do own/control, or plan to own/control a 10% or greater interest of any provider of Wisconsin Medicaid Services in any Wisconsin Medicaid Program. | |
| C. |  | By my signature below, I affirm I, or an immediate family member, do receive payment, or plan to receive payment of more than $3000 within a 12-month period from any provider of Wisconsin Medicaid Services in any Wisconsin Medicaid Program. | |

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| **CONFLICT OF INTEREST DESCRIPTION AND MITIGATION** | | | | |
| Name – Employee / Own Business | | Address – Employer / Own Business | | |
| Percentage of Provider Owned / Controlled | | Payment Received over the Last 12 Months | | |
| Description – Including position title, work duties, work schedule, etc. | | | | |
| Mitigation Strategy – Including steps to be taken, responsible parties and timeframes. | | | | |
| By my signature below, I affirm the information I have provided is true. | | | | |
| **SIGNATURE** – Employee | | | Date Signed | |
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| **ICA / FEA PROVIDER AGENCY DECISION AND RECOMMENDATION** | | | | |
| **Decision:** | | | | |
|  | Mitigation strategy is sufficient to mitigate the conflict of interest. | | | |
|  | Mitigation strategy is not sufficient to mitigate the conflict of interest. | | | |
| **Recommendation** | | | | |
| **SIGNATURE** – ICA / FEA Supervisor | | | | Date Signed |
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| **DHS – IRIS SECTION DECISION AND RECOMMENDATION** | | | | |
| **Decision:** | | | | |
|  | Mitigation strategy is sufficient to mitigate the conflict of interest. | | | |
|  | Mitigation strategy is not sufficient to mitigate the conflict of interest. | | | |
| **Recommendation** | | | | |
| **SIGNATURE** – DHS IRIS Section Chief, or Designee | | | | Date Signed |
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