|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **DEPARTMENT OF HEALTH SERVICES**  Division of Medicaid Services  F-00236B (03/2024) | | | | | | **STATE OF WISCONSIN**  Wisconsin Statutes  § 46.287 (2) (c) | | |
| **request for a state fair hearing – IRIS** | | | | | | | | |
| **INSTRUCTIONS:** | | Completion of this form is voluntary. The personally identifiable information collected on this form is used to identify the case and process the request. | | | | | | |
| Participant’s Name (Last, First) | | | | | | Phone Number | | Medicaid ID Number |
| Mailing Address | | | | | | Program  IRIS | | |
| City | | | | Zip Code | | IRIS Consultant Agency | | |
| Today’s Date | | | | | | Effective Date of Action | | |
| Briefly describe the reason for the appeal: | | | | | | | | |
|  | | | | | | | | |
| Yes | No | | Did you receive a Notice of Action from your IRIS Consultant Agency or the Department?  If you answered 'yes' you must attach a copy of the notice when submitting this form. | | | | | |
| **Continuing Your Services During an Appeal of a Reduction or Termination of a Current Service**  .  During the appeal process, you have the right to request service continuation until a hearing decision is rendered. Requests for continuation of services must be received (postmarked) **on or before the effective date of the intended action**. You may be responsible for repaying the cost of these services if you lose your appeal. However, at the discretion of the Department of Health Services, you may not be required to repay these costs.  Check this box if you would like to request your current services to continue during your appeal.  You, or your legal representative, have a right to a free copy of your records, relevant to your appeal. To request a copy, please contact your IRIS consultant agency or the IRIS Call Center at 1-888-515-4747.  If you need this form in another language, Braille, or large print, then please contact your IRIS consultant agency or the IRIS Call Center at 1-888-515-4747. Interpreter and translation services are available, free-of-charge. | | | | | | | | |
| **SIGNATURE** – Participant | | | | | | Date Signed | | |
|  | | | | | |  | | |
| **SIGNATURE** – Legal Representative (if applicable) | | | | | | Date Signed | | |
| Mail or fax this form **AND** a copy of the Notice of Action/decision letter to: | | | | | | | | |
| IRIS Request for Fair Hearing  Wisconsin Division of Hearings and Appeals  P.O. Box 7875  Madison, WI 53707-7875 | | | | | OR | | Fax: 608-264-9885 | |