|  |  |  |  |
| --- | --- | --- | --- |
| **DEPARTMENT OF HEALTH SERVICES**  Division of Medicaid Services  F-01200 (02/2017) | | **STATE OF WISCONSIN** | |
| **IRIS PROGRAM COST SHARE REPAYMENT AGREEMENT** | | | |
| **INSTRUCTIONS:** | Please review the information below. When finished, please sign, date, and return one copy of this form by either sending it in the enclosed postage-paid envelope or by faxing it to <<ICA Fax>> by      . | | |
| Participant’s Name (Last, First, MI) | | Date of Birth | |
| You agreed to repay your overdue cost share amount of $      by adding $      to your current monthly payment amount. Your overdue cost share will be paid in approximately       months. Your repayment plan begins with the cost share due on      . | | | |
| **IMPORTANT PAYMENT INFORMATION** | | | |
| * The repayment agreement is based on your current cost share. If your current monthly cost share increases, your repayment amount will also increase. | | | |
| * Cost share payments are due on the first of each month to your Fiscal Employer Agent: | | | |
| <<FEA Address>> | | | |
| * Payments arriving after the fifth of the month are past due. | | | |
| * Paying your monthly cost share helps maintain your IRIS program eligibility. Your cost share must be paid to maintain Medicaid eligibility and to continue your enrollment in the IRIS program. | | | |
| * You may be responsible for paying for any services you receive if your Medicaid and IRIS program eligibility ends. | | | |
| Your signature below indicates that you have read, understand and agree to the above terms. Failure to adhere to this repayment plan will result in your referral for disenrollment from Medicaid and the IRIS program. | | | |
| **SIGNATURE** – Participant/Guardian | | | Date Signed |
|  | | |  |
| **SIGNATURE** – IRIS Program Representative | | | Date Signed |
|  | | |  |