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| **DEPARTMENT OF HEALTH SERVICES**Division of Medicaid ServicesF-01204 (07/2022) | **STATE OF WISCONSIN** |
| **NOTICE OF ACTION – IRIS PROGRAM** |
| Participant’s Name (Last, First)      | Issuing IRIS AgencyICA |
| NOA Reference Number      | Decision Date      | Effective Date      |
| The purpose of this notice is to inform you about the IRIS Program’s decision to select action your       |
| The program has reached this decision based on the following factor(s): |
| **[ ]** Specialized transportation definition does not cover reimbursement to yourself. |
| **[ ]** The request does not meet an IRIS Medicaid Waiver Service definition. |
| **[ ]** The request does not meet the Customized Goods, Service, or Support definition. |
| **[ ]** The request is not an effective way to support your outcome. |
| **[ ]** The request is not considered a safe way to support your outcome. |
| **[ ]** The request is not considered the most cost effective way to support your outcome. |
| **[ ]** The request was determined to be sought under fraudulent circumstances. |
| **[ ]** The reviewed request is covered under Medicaid State Plan. |
| **[ ]** The reviewed request was not on an approved plan. |
| [ ]  You have an outstanding cost share that must be paid before you can re-enter the program.  |
| [ ]  You were previously disenrolled for budget and/or employer authority  |
| [ ]  You have failed to develop an IRIS plan.  |
| **[ ]** There is insufficient documentation to justify your request at this time. |
| **[ ]** You are not functionally eligible to remain in the IRIS program. |
| **[ ]** You do not need this good, service, or support to support your outcome. |
| **[ ]** You do not reside in an eligible living arrangement to maintain IRIS enrollment. |
| **[ ]** You have failed to meet the necessary contact requirements. |
| **[ ]** Your outcome is already supported in another way so the request is duplicative. |
| [ ]  The original good, service or support was previously approved in error. |
| [ ]  This is not an allowable good, service, or support per the approved HCBS Waiver. |
| [ ]  The request contradicts IRIS Policy. |
| [ ]  You do not meet the required criteria to receive the SSI-E Supplemental Benefit. |
| [ ]  You are not eligible for Self-Directed Personal Care services. |
| Specifically,       |