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| **DEPARTMENT OF HEALTH SERVICES**  Division of Medicaid Services  F-01210 (12/2024) | | | | | | | | | |  | | **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.  Please attach this form and all other relevant accompanying documents to the following link, in the appropriate file:<https://share.health.wisconsin.gov/ltc/teams/iris/iba/SitePages/Home.aspx>.See page 4 for detailed instructions. | | | | | | | | | | | |
| **SECTION I – DEMOGRAPHICS (ALL FIELDS MUST BE FILLED)** | | | | | | | | | | | | | | |
| Participant’s Name (Last, First)  Click here to enter text. | | | | | | | | | | Participant’s MCI Number  Click here to enter text. | | | | |
| County of Residence  Click here to enter text. | | | | | | | | | | Date of Birth  Click here to enter text. | | | | |
| Guardian or Legal Decision Maker (if applicable)  Click here to enter text. | | | | | | | | | | IRIS Consultant  Click here to enter text. | | | | |
| IRIS Start Date  Click here to enter text. | | | | | | | | | | Date Participant Identified Need  Click here to enter text. | | | | |
| **SECTION II – PRE-SUBMISSION PROCESS** | | | | | | | | | | | | | | |
| Has the Budget Amendment (BA) pre-submission process been completed, as detailed in the program policy? | | | | | | | | | | | | | | |
| Yes  No | | | | | | | | | | | | | | |
| **SECTION III – SUPPORTS/SERVICES/GOODS** | | | | | | | | | | | | | | |
| Proposed IRIS-Funded Supports/Services/Goods with Existing Budget  To add more table rows: Select the plus sign that appears when you click in the last cell of the table. | | | | | | | | | | | | | | |
| **Supports/Services/Goods** | | | | **Approved Budget Amendment or One-Time Expense** | **Vendor/Provider** | | | **Number of Units**  **Per Frequency** | | | **Unit Type** | **Rate Per Unit** | **Total Monthly Service Amount** | **If a Daily Rate, Enter the Total Daily Care Hours** |
| Click here to enter text. | | | | Yes  No | Click here to enter text. | | | Click here to enter text. | | | Choose a unit type. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | | | | Yes  No | Click here to enter text. | | | Click here to enter text. | | | Choose a unit type. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | | | | Yes  No | Click here to enter text. | | | Click here to enter text. | | | Choose a unit type. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | | | | Yes  No | Click here to enter text. | | | Click here to enter text. | | | Choose a unit type. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | | | | Yes  No | Click here to enter text. | | | Click here to enter text. | | | Choose a unit type. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | | | | Yes  No | Click here to enter text. | | | Click here to enter text. | | | Choose a unit type. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | | | | Yes  No | Click here to enter text. | | | Click here to enter text. | | | Choose a unit type. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | | | | Yes  No | Click here to enter text. | | | Click here to enter text. | | | Choose a unit type. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | | | | Yes  No | Click here to enter text. | | | Click here to enter text. | | | Choose a unit type. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Additional Non-IRIS Care Hours/Supports/Services/Goods  To add more table rows: Select the plus sign that appears when you click in the last cell of the table. | | | | | | | | | | | | | | |
| **Supports/Services/Goods** | | | |  | | **Vendor/**  **Provider** | | **Number of Units**  **Per Frequency** | | | **Unit Type** | **Rate Per Unit** | **Total Monthly Service Amount** | **If a Daily Rate, Enter the Total Daily**  **Care Hours** |
| Click here to enter text. | | | |  | | Click here to enter text. | | Click here to enter text. | | | Choose a unit type. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | | | |  | | Click here to enter text. | | Click here to enter text. | | | Choose a unit type. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | | | |  | | Click here to enter text. | | Click here to enter text. | | | Choose a unit type. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | | | |  | | Click here to enter text. | | Click here to enter text. | | | Choose a unit type. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| New BA Requested Supports/Services/Goods | | | | | | | | | | | | | | |
| **Supports/Services/Goods** | | | | **Approved Budget Amendment or One-Time Expense** | **Vendor/Provider** | | | **Number of Units**  **Per Frequency** | | | **Unit Type** | **Rate Per Unit** | **Total Monthly Service Amount** | **If a Daily Rate, Enter the Total Daily Care Hours** |
| Click here to enter text. | | | | Yes  No | Click here to enter text. | | | Click here to enter text. | | | Choose a unit type. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Additional information regarding proposed plan (if necessary): | | | | | | | | | | | | | | |
| Click here to enter text. | | | | | | | | | | | | | | |
| **SECTION IV – ADDITIONAL PLAN INFORMATION** | | | | | | | | | | | | | |
| 1 | What is the participant’s living arrangement? | | | | | In their home or someone else’s home (leased or owned)  Adult Family Home (AFH), 1-2 bed  AFH, 3-4 bed  Residential Care Apartment Complex (RCAC)  Other, specify: Click here to enter text. | | | | | | | |
| 2 | If living with others, how many family members reside in the home? | | | | | Click here to enter text. | | | | | | | |
| 3 | If living with others, how many home and community-based (HCBS) waiver recipients live in the home? | | | | | Click here to enter text. | | | | | | | |
| 4 | If the participant is employed, how many hours do they work per week? How many of those hours, if any, are unsupported (no paid or unpaid/informal support)? | | | | | Click here to enter text. | | | | | | | |
| 5 | Describe the participant’s current involvement in the community (social, recreational, religious/spiritual, volunteer activities/events, etc.). | | | | | Click here to enter text. | | | | | | | |
| 6 | If the participant has regular independent time without supports or care provided, indicate how much time per week and when this typically occurs. | | | | | Click here to enter text. | | | | | | | |
| **SECTION V – JUSTIFICATION FOR BA REQUEST** | | | | | | | | | | | | | |
| 1 | What prompted this BA request (new unmet need/care change, etc.)? | | | | | Click here to enter text. | | | | | | | |
| 2 | Select the requested length of time that reflects the duration of the requested supports/services/goods. | | | | | Time limited (specify length of time): Click here to enter text.  Ongoing | | | | | | | |
| 3 | What long-term care need and associated long-term care outcome are associated with this request? | | | | | Click here to enter text. | | | | | | | |
| 4 | How is the requested service the most effective and cost-efficient way to meet the identified long-term care need? | | | | | Click here to enter text. | | | | | | | |
| 5 | How are existing services and resources, including MA card services, unpaid or informal supports, and community resources being maximized? | | | | | Click here to enter text. | | | | | | | |
| 6 | How are services that address health and safety being prioritized? | | | | | Click here to enter text. | | | | | | | |
| **SECTION VI – SUPPORTING DOCUMENTATION** | | | | | | | | | | | | | |
| Required for All Requests | | | | | | | | Required When Applicable or Requested | | | | | |
| Long-Term Care Functional Screen  IRIS Service Plan  IRIS Budget  IRIS Participant Education: Budget Amendments form  Provider Quote Comparison form (except for PHW providers) | | | | | | | | Participant’s FEA Spending Report  IRIS Caregiver Daily Task Schedule  Provider Budget  AFH Care and Supervision/Room and Board  Rate Justification Documentation (for program transfers)  Mileage Justification (for community transportation services)  MA Denial and/or Appeal Letter(s)  Remand Letter(s)  Behavior Support Plan/Behavior Tracking Documentation  Personal Care Screen Tool  Critical Incidents (as applicable to BA request only)  Nurse Consult Documentation  WINS Task Letter  Restrictive Measures Approval Letter | | | | | |
| The Department may request additional documentation not specifically listed here, as necessary, to complete the review of this request. | | | | | | | | | | | | | | | |
| **SIGNATURE OF INDIVIDUAL DRAFTING REQUEST:** By completing, signing, and submitting this form, you are confirming that you have completed all required fields. You confirm that you have assisted the participant with completing this individualized request and with gathering all necessary documents. To the best of your knowledge, your signature further confirms that all information provided has been reviewed and verified for accuracy. | | | | | | | | | | | | | | | |
| Signature of ICA Staff  Click here to enter text. | | | | | | | | Email  Click here to enter text. | | | | | |
| **SIGNATURE OF INDIVIDUAL REVIEWING REQUEST:** By signing this form, you are confirming that you have reviewed all required fields as completed by the BA drafter. To the best of your knowledge, your signature further confirms that you have assisted with verifying that the information contained in this form is accurate, in accordance with policy, and contains all necessary documents. | | | | | | | | | | | | | |
| Signature of ICA Quality Review Staff  Click here to enter text. | | | | | | | | Email  Click here to enter text. | | | | | |

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| **IRIS BUDGET AMENDMENT REQUEST: FORM INSTRUCTIONS** | | | | | | | | | | | | | | |
| **How to Submit This Form**  This form and any relevant accompanying forms should be attached electronically to the request within the Department’s enterprise care management system. Please attach this form and all other relevant accompanying documents to the following link, in the appropriate file:<https://share.health.wisconsin.gov/ltc/teams/iris/iba/SitePages/Home.aspx>.  **Person Completing This Form**  The ICA staff that completes this form must also provide the Department with all other 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.  **Person Reviewing This Form**  The ICA staff that reviews this form for quality must also ensure that all other relevant information and documents are provided to the Department. When reviewing this form, you are assuring that the information provided has been reviewed and is accurate to the best of your knowledge. | | | | | | | | | | | | | | |
| **SECTION I – DEMOGRAPHICS (ALL FIELDS MUST BE FILLED)** | | | | | | | | | | | | | | |
| Complete all fields with requested demographic information. All information provided should be consistent with the participant’s record in the Department’s Enterprise care management system. | | | | | | | | | | | | | | |
| **SECTION II – PRE-SUBMISSION PROCESS** | | | | | | | | | | | | | | |
| Has the BA pre-submission process been completed, as detailed in the program policy? | | | | | | | | | | | | | | |
| Check the box to confirm you have reviewed the pre-submission process and completed all steps outlined in the program policy—Additional Funding Requests: Budget Amendment Requests, P-03656. | | | | | | | | | | | | | | |
| **SECTION III – SUPPORTS/SERVICES/GOODS** | | | | | | | | | | | | |
| Proposed IRIS-Funded Supports/Services/Goods with Existing Budget  **Instructions:** Complete this section to indicate the proposed plan, which provides a complete picture of plan updates made if the BA request is approved. This list must be comprehensive, meaning that all IRIS-funded supports/services/goods that will remain on the plan if the BA request is approved **MUST** be listed in this section. | | | | | | | | | | | | |
| **Supports/Services/Goods** | | | **Approved Budget Amendment or One-Time Expense** | **Vendor/Provider** | | | **Number of Units**  **Per Frequency** | | **Unit Type** | **Rate Per Unit** | **Total Monthly Service Amount** | **If a Daily Rate, Enter the Total Daily Care Hours** |
| Enter each IRIS waiver support/service/ good that is on the participant’s plan and would remain there if the BA request is approved.  You may add additional rows to this section if necessary to accommodate all goods/services/ supports on current approved plan. | | | Check yes or no to indicate if the support/service/good listed has an already existing BA or OTE. | Enter the name of the provider(s) or vendor(s) providing the service/support/good.  Specific titles/names are required. If there are multiple providers, list **ALL** providers. | | | Enter the number of units per frequency (10/week, 1/month, etc.) that will exist on the proposed plan. | | Select the type of unit from the drop down. | Enter the rate per unit.  PHW rates provided must be written both without and with taxes. | 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 multiplied by 53 and divided by 12. | For providers with a daily rate, enter the number of hours in a day that a participant receives care coverage from this support/service/good.  If not applicable to this support/service/good, enter N/A. |
| Additional Non-IRIS Care Hours/Supports/Services/Goods  **Instructions:** Complete this section to indicate any care/service/support/activity on the plan that is funded by a source ***other*** than IRIS, or otherwise non-funded. All care/services/supports/activities included here should be specific to the request being made.  This includes any of the following:   * MA card services (personal care, medical equipment/supplies, etc.) (Note: If eligible for personal care, but not receiving that, include why here.) * Services provided by other funding sources (DVR, HUD, etc.) * Any unpaid or informal supports (transportation provided by a friend or neighbor, job support by employer, etc.) * Any regularly scheduled activity that equates to hours where the participant would otherwise be provided care (employment, volunteer work, social activities, religious/spiritual engagements, etc.). | | | | | | | | | | | | |
| **Supports/Services/Goods** | | |  | | **Vendor/**  **Provider** | | **Number of Units**  **Per Frequency** | | **Unit Type** | **Rate Per Unit** | **Total Monthly Service Amount** | **If a Daily Rate, Enter the Total Daily Care Hours** |
| Enter the care/service/support/activity currently on the plan that is funded by a source ***other*** than IRIS or otherwise non-funded.  You may add additional rows to this section if necessary. | | |  | | Enter the name of the provider(s) or vendor(s) providing the care/services/supports/activities, if applicable.  Specific titles/names are required. If there are multiple providers, list **all** providers. If there is no provider (e.g., independent social activity), please leave blank. | | Enter the number of units per frequency (10/week, 1/month, etc.) on the current approved plan. | | Select the type of unit from the drop down. | Enter the rate per unit.  PHW rates provided must be written both without and with taxes. | 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 multiplied by 53 and divided by 12. | For providers with a daily rate, enter the number of hours in a day that a participant receives care coverage from this care/service/support/activity.  If not applicable to this care/service/support/activity, enter N/A. |
| New BA Requested Supports/Services/Goods  **Instructions:** Complete this section to indicate the requested service. Provide all requested information and calculations as indicated. | | | | | | | | | | | | |
| **Supports/Services/Goods** | | | **Approved Budget Amendment or One-Time Expense** | **Vendor/Provider** | | | **Number of Units**  **Per Frequency** | | **Unit Type** | **Rate Per Unit** | **Total Monthly Service Amount** | **If a Daily Rate, Enter the Total Daily Care Hours** |
| Enter the allowable IRIS waiver support/service/good that is being requested.  You may **not** add additional rows, and you may not combine multiple supports/services/goods into one line. | | | Check yes or no to indicate if the support/service/good listed has an already existing BA or OTE. | Enter the name of the requested provider(s) or vendor(s) for the service/support/ good.  Specific titles/names are required. If there are multiple providers, list **ALL** providers. | | | Enter the number of units per frequency (10/week, 1/month, etc.) being requested. | | Select the requested type of unit from the drop down. | Enter the requested rate per unit.  PHW rates provided must be written both without and with taxes. | Enter the total monthly service amount that is being requested. Calculate this by using the total weekly service amount multiplied by 53 and divided by 12.  The total amount of the request is also calculated and adjusted according to available funds in participant’s existing budget. | For providers with a daily rate, enter the number of hours in a day that a participant receives care coverage from this support/service/good.  If not applicable to this support/service/good, enter N/A. |
|  | | | | | | | | | | | |  |
| Additional information regarding proposed plan (if necessary) | | | | | | | | | | | | |
| **Instructions:** Complete this section when there are additional details about the proposed plan that would not fit within the table provided above. Any narrative information, supplemental details, or clarifications can be provided here.  Examples include additional details around service adjustments made for the request, like whether this Budget Amendment request replaces any currently active Budget Amendment(s), if it’s approved. | | | | | | | | | | | | |
| **SECTION IV – ADDITIONAL PLAN INFORMATION** | | | | | | | | | | | | |
| 1 | | What is the participant’s living arrangement? | | | | Select the participant’s current living arrangement. If “Other,” provide a written response in the text box. | | | | | | |
| 2 | | If living with others, how many family members reside in the home? | | | | If the participant lives with others, indicate the total number of family members residing in the home. | | | | | | |
| 3 | | If living with others, how many home and community-based (HCBS) waiver recipients live in the home? | | | | If the participant lives with others, indicate the total number of HCBS waiver recipients residing in the home. | | | | | | |
| 4 | | If the participant is employed, how many hours do they work per week? How many of those hours, if any, are unsupported (no paid or unpaid/informal support)? | | | | If the participant is employed, indicate how many hours they work per week. Then indicate how many of those work hours are unsupported, meaning no services or unpaid/informal supports are being provided to the participant. | | | | | | |
| 5 | | Describe the participant’s current involvement in the community (social, recreational, religious/spiritual, volunteer activities/events, etc.). | | | | Describe the community involvement that the participant is currently engages in, regardless of funding or support level. | | | | | | |
| 6 | | If the participant has regular independent time without supports or care provided, indicate how much time per week and when this typically occurs. | | | | Describe the participant’s independent time spent where they do not receive supports or care, meaning no services or unpaid/informal supports are being provided to the participant. Indicate how much independent time and when this independent time occurs per week, on average. | | | | | | |
| **SECTION V – JUSTIFICATION FOR BA REQUEST** | | | | | | | | | | | | |
| 1 | | What prompted this BA request (new unmet need/care change, etc.)? | | | | Indicate what prompted this BA request (new unmet need/care change, etc.) in a brief statement or phrase. | | | | | | |
| 2 | | Select the requested length of time that reflects the duration of the requested supports/services/goods. | | | | Select (and fill in, if applicable) the requested length of time that reflects the duration of the requested supports/services/goods. | | | | | | |
| 3 | | What long-term care need and associated long-term care outcome are associated with this request? | | | | Provide the identified long-term care need and associated long-term care outcome associated with this request. | | | | | | |
| 4 | | How is the requested service the most effective and cost-efficient way to meet the identified long-term care need? | | | | Explain how the services and resources available to the participant are being utilized in combination to support the participant in the most effective and efficient way.  This section is intended to capture the ways in which the participant’s support team has ensured all resources are being maximized and accessed to the fullest in support of the participant and their needs. | | | | | | |
| 5 | | How are existing services and resources, including MA card services, unpaid or informal supports, and community resources being maximized? | | | | Explain how the participant’s current plan was evaluated to ensure that services required for health and safety are being prioritized. For service prioritization, refer to the domains and outcomes portion of the IRIS Service Plan Development policy chapter. | | | | | | |
| 6 | | How are services that address health and safety being prioritized? | | | | Explain how the requested service is the most effective and cost-efficient wat to meet the participant’s identified long-term care need. Be specific about which of the participant’s long-term care need(s) will benefit through this budget amendment request in the most effective and efficient way. | | | | | | |
| **SECTION VI – SUPPORTING DOCUMENTATION** | | | | | | | | | | | | |
| Required for All Requests | | | | | | | | Required When Applicable or Requested | | | | |
| Check the box for each required document provided with this request, to verify it has been attached.  For documentation requirements, see Additional Funding Requests: Budget Amendment Request policy and documentation requirements resource. | | | | | | | | Check the box for each document provided with this request, including additional documents, to verify it has been attached. The Department may request additional documentation not specifically listed here to complete the review of this request.  For documentation requirements, see Additional Funding Requests: Budget Amendment Request policy and documentation requirements resource. | | | | |
| The Department may request additional documentation not specifically listed here, as necessary, to complete the review of this request. | | | | | | | | | | | | |
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