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| **DEPARTMENT OF HEALTH SERVICES**  Division of Medicaid Services  F-01210A (12/2024) | | | **STATE OF WISCONSIN** | |
| **IRIS BUDGET AMENDMENT: PROVIDER QUOTE COMPARISON** | | | | |
| **INSTRUCTIONS:** | Completion of this form is not required through Wisconsin State Statute; however, completion of this form is an IRIS Program requirement.  See page 2 of this form for detailed instructions. | | | |
|  | | **Quote Number 1** | **Quote Number 2** | **Quote Number 3** |
| Provider Agency/Vendor | |  |  |  |
| Provider Contact Person | |  |  |  |
| Provider Contact Information | |  |  |  |
| Service Requested | |  |  |  |
| Number of Units Requested Per Frequency | |  |  |  |
| Unit Type | | Choose a unit type. | Choose a unit type. | Choose a unit type. |
| Rate Per Unit | |  |  |  |
| Total Monthly Cost | |  |  |  |
| Provider Budget Attached | | Yes  No | Yes  No | Yes  No |
| **Additional Providers Contacted (if applicable)** | | | | |
|  | | **Additional Provider 1** | **Additional Provider 2** | **Additional Provider 3** |
| Provider Agency/Vendor | |  |  |  |
| Provider Contact Person | |  |  |  |
| Provider Contact Information | |  |  |  |
| Reason for Not Including Provider Above | |  |  |  |
| By completing and submitting this form, you are confirming that you have completed all required fields. You further confirm that all information provided has been reviewed, verified, and is accurate to the best of your knowledge.  Please attach this form and any other relevant accompanying documents to the following link, in the appropriate file:  <https://share.health.wisconsin.gov/ltc/teams/iris/iba/SitePages/Home.aspx> | | | | |
| Name of ICA Staff | | | Email | |

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| **IRIS BUDGET AMENDMENT PROVIDER QUOTE COMPARISON: FORM INSTRUCTIONS** |
| FORM REQUIREMENTS: |
| Complete all fields within this document and ensure all required documentation is provided. All quotes provided on this form must be specific to the participant associated with this request and must have been obtained for the purposes of this specific request. Each Budget Amendment request requires at least three comparable quotes\* from eligible providers to be considered complete.  \*If the participant cannot obtain a quote from a provider due to issues like provider availability, willingness, or access, the ICA staff must complete the “Additional Providers Contacted” section to verify attempts at gathering additional quotes. |
| **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. |
| **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. |

PROVIDER QUOTE INFORMATION:

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| **Provider Agency/Vendor** | Insert the name of the provider. |
| **Provider Contact Person** | Insert the name of the person contacted from this provider. |
| **Provider Contact Information** | Insert phone number or email of the contact person indicated above. |
| **Service Requested** | Insert the service being requested. |
| **Number of Units Requested Per Frequency** | Insert the number of units being requested per frequency (10/week, 1/month, etc.). |
| **Unit Type** | Select the type of unit from the drop down. |
| **Rate Per Unit** | Insert the rate quoted by this provider. |
| **Total Monthly Cost** | Insert the total monthly cost quoted by this provider. This is calculated using the number of units multiplied by the rate. |
| **Provider Budget Attached** | Check yes or no to indicate if the provider budget is attached.  The provider budget should include a breakdown of the following expenses:   * Wages/salaries (direct care and administrative staff) * Daily staffing patterns (including overnights) * Detailed program administrative expenses * Administrative overhead * Taxes/FICA * Benefits (fringe, health insurance, PTO, etc.) * Training/recruitment * Insurance/liability * Audit * Office/program supplies * Vehicle expenses/mileage * Operating expenses |
| **Additional Providers Contacted:** This section should be completed when a participant is unable to obtain a minimum of three quotes because a provider is unavailable, unwilling, or inaccessible to the participant for any reason. Additionally, this section may be used to demonstrate when other providers have been contacted beyond the three provided in the quote comparison above. | |
| **Reason for Not Including Provider Above** | Describe the reason this provider was not included in the quote comparison above as one of the three providers (for example, provider is not currently taking new clients). |