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| **DEPARTMENT OF HEALTH SERVICES**  Division of Medicaid Services  F-01240 (02/2017) | | | | | | | **STATE OF WISCONSIN**  Completion of this form meets the  requirements and conditions of the  CMS-approved Medicaid Waiver Programs | | | |
| **IRIS CRITICAL INCIDENT RECONCILIATION** | | | | | | | | | | |
| **INSTRUCTIONS:** | This form is to be completed by 1-2 Bed Adult Family Home Certifying Agency. Agency is responsible for incident reconciliation between ICA and 1-2 Bed AFH Providers. This form is to be submitted quarterly, in order to be in compliance with DHS and DQA reporting requirements.  Personally identifiable information on this form is collected to verify that the form is complete, and will be used only for this purpose. | | | | | | | | | |
| **REPORTING PERIOD:** Choose Quarter | | | | | | | | | | |
| Participant’s Name (Last, First) | | Participant’s MCI Number | IRIS Consultant Agency | AFH Provider | Date of Incident | Date Incident Received from IRIS Consultant Agency | | Date Incident Received from Provider | Type of Incident | Brief Description of Incident |
|  | |  |  |  | date | date | | date | Choose one |  |
|  | |  |  |  | date | date | | date | Choose one |  |
|  | |  |  |  | date | date | | date | Choose one |  |
|  | |  |  |  | date | date | | date | Choose one |  |
|  | |  |  |  | date | date | | date | Choose one |  |
|  | |  |  |  | date | date | | date | Choose one |  |
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|  | |  |  |  | date | date | | date | Choose one |  |
|  | |  |  |  | date | date | | date | Choose one |  |
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|  | |  |  |  | date | date | | date | Choose one |  |
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|  | |  |  |  | date | date | | date | Choose one |  |
|  | |  |  |  | date | date | | date | Choose one |  |
|  | |  |  |  | date | date | | date | Choose one |  |
|  | |  |  |  | date | date | | date | Choose one |  |
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|  | |  |  |  | date | date | | date | Choose one |  |
|  | |  |  |  | date | date | | date | Choose one |  |
|  | |  |  |  | date | date | | date | Choose one |  |