|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **DEPARTMENT OF HEALTH SERVICES**  Division of Medicaid Services  F-01310A (02/2017) | | | **STATE OF WISCONSIN** | | |
| **IRIS PROGRAM CONFLICT OF INTEREST DISCLOSURE – PARTICIPANT** | | | | | |
| **INSTRUCTIONS:** | Conflicts of Interest involving participants must be addressed in accordance with IRIS Work Instruction Manual Section 10.3A.1.  Completion of this form is not required by Wisconsin Statute; however, it is a requirement of the IRIS Program to mitigate all identified conflicts of interest. Personally identifiable information on this form is collected to verify that the request is complete, and will be used only for this purpose. | | | | |
| **SECTION I – DEMOGRAPHICS** | | | | | |
| Participant’s Name (Last, First) | | | Participant’s MCI Number | | |
| Participant’s Address | | | Participant’s Phone Number | | |
| Participant’s City/State/Zip | | | Participant’s Email Address | | |
| **SECTION II – DESCRIPTION OF CONFLICT OF INTEREST** | | | | | |
| Describe the conflict of interest. | | | | | |
|  | | | | | |
| Conflict of Interest Identified Through: | | | | | |
| Participant Self-Report | | ICA Observation | FEA Observation | | DHS Record Review |
| **SECTION III – DESCRIPTION OF RESOLUTION STRATEGIES** | | | | | |
| Describe the resolution strategies selected by the IRIS participant. | | | | | |
|  | | | | | |
| **SECTION IV – DESCRIPTION OF THE IMPLEMENTATION PLAN** | | | | | |
| Describe the implementation plan for resolution strategies identified in Section III. | | | | | |
|  | | | | | |
| **SECTION V – DESCRIPTION OF THE MONITORING PLAN** | | | | | |
| Describe the IRIS Consultant’s plan for monitoring the resolution strategies and implementation plan identified in Sections III and IV. | | | | | |
|  | | | | | |
| I understand that as an IRIS participant and/or legal representative and/or guardian, I am responsible for ensuring that I/we complete the activities in Sections III and IV according to the descriptions above. | | | | | |
| **SIGNATURE** – Participant | | | | Date Signed | |
|  | | | |  | |
| **SIGNATURE** – Legal Representative and/or Guardian | | | | Date Signed | |
|  | | | |  | |
| I understand that as the IRIS Consultant, I am responsible for ensuring that I assist the participant and/or legal representative in executing the resolution strategies and implementation plan identified in Sections III and IV as needed. I also understand that I am responsible for executing the monitoring plan identified in Section V. | | | | | |
| **SIGNATURE** – IRIS Consultant | | | | Date Signed | |
|  | | | |  | |