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| **DEPARTMENT OF HEALTH SERVICES**  Division of Medicaid Services  F-01314 (02/2017) | | | | **STATE OF WISCONSIN** |
| **IRIS PROGRAM EMPLOYMENT CHECKLIST** | | | | |
| **INSTRUCTIONS:** | | Completion of this form is not required through Wisconsin State Statute; however, completion of this form is an IRIS program requirement. The IRIS consultant must acknowledge the review of this form. | | |
| Participant’s Name (Last, First) | | | Employee’s Name (Last, First) | |
| **SECTION I: EMPLOYER ORIENTATION** | | | | |
|  | Discussed benefits, responsibilities and alternatives to serving as the employer of record | | | |
|  | Reviewed processes and paperwork for hiring and terminating participant-hired workers and vendors, including how to submit timesheets | | | |
|  | Discussed background checks and credentialing requirements | | | |
|  | Discussed budget management and authority | | | |
|  | Discussed fraud and abuse of public dollars | | | |
|  | Reviewed consultant’s contact information, chosen FEA’s contact information and IRIS call center contact information | | | |
| **SECTION II: EMPLOYEE PAPERWORK (AS NECESSARY)** | | | | |
|  | Background Disclosure ([F-82064](http://www.dhs.wisconsin.gov/forms/f8/f82064.docx)) | | | |
|  | Background Disclosure Addendum ([F-01246](http://www.dhs.wisconsin.gov/forms/F0/F01246.docx)) | | | |
|  | [W-4](http://www.irs.gov/pub/irs-pdf/fw4.pdf) | | | |
|  | [W-9](http://www.irs.gov/pub/irs-pdf/fw9.pdf) | | | |
|  | Application for Employer Identification Number ([FSS-4](http://www.irs.gov/pub/irs-pdf/fss4.pdf)) | | | |
|  | Employment Eligibility Verification ([I-9](http://www.uscis.gov/sites/default/files/files/form/i-9.pdf)) | | | |
|  | Employer/Payer Appointment of Agent ([F2678](http://www.irs.gov/pub/irs-pdf/f2678.pdf)) | | | |
|  | Participant-Hired Worker Employee Set-Up ([F-01201](http://www.dhs.wisconsin.gov/forms/F0/F01201.docx)) | | | |
|  | IRIS Participant-Hired Worker Relationship Identification ([F-01201A](http://www.dhs.wisconsin.gov/forms/F0/F01201a.docx)) | | | |
|  | Supportive Home Care/Self-Directed Personal Care/Respite Care Training Verification ([F-01201B](http://www.dhs.wisconsin.gov/forms/F0/F01201b.docx)) | | | |
|  | Employer/Employee Agreement ([F-01201C](http://www.dhs.wisconsin.gov/forms/F0/F01201c.docx)) | | | |
|  | MA Provider Agreement ([F-00180](http://www.dhs.wisconsin.gov/forms/F0/f00180.doc)), ([F-00180A](http://www.dhs.wisconsin.gov/forms/F0/f00180a.doc)) and/or ([F-00180B](http://www.dhs.wisconsin.gov/forms/F0/f00180b.doc)) | | | |
|  | Confidential Information Release Authorization ([F-82009](http://www.dhs.wisconsin.gov/forms/F8/F82009.doc)) | | | |
|  | Power of Attorney and Declaration of Representative ([F2848](http://www.irs.gov/pub/irs-pdf/f2848.pdf)) | | | |
|  | Power of Attorney ([F-00036](http://www.dhs.wisconsin.gov/forms/AdvDirectives/F00036.pdf)) | | | |
| **SECTION III: MISCELLANEOUS** | | | | |
|  | OSHA Standard Precautions | | | |
|  | Standard Precautions for Bloodborne Transmission | | | |
| My signature below indicates that my IRIS consultant has reviewed this document with me and I have had the opportunity to have all of my questions asked. My signature also indicates that I understand the material above as presented to me. I understand that if I have questions in the future that I may address them with my IRIS consultant. | | | | |
| **SIGNATURE** – Participant | | | | Date Signed |
|  | | | |  |
| **SIGNATURE** – Guardian (if applicable) | | | | Date Signed |
|  | | | |  |
| My signature below indicates that I personally reviewed this document with the participant and/or guardian and provided them with the opportunity to ask questions. | | | | |
| **SIGNATURE –** IRISConsultant | | | | Date Signed |
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