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| **DEPARTMENT OF HEALTH SERVICES**  Division of Medicaid Services  F-01319 (02/2017) | | | **STATE OF WISCONSIN** | |
| **IRIS INVOLUNTARY DISENROLLMENT REQUEST** | | | | |
| **INSTRUCTIONS:** | | IRIS Consultant Agencies (ICAs) must complete this form to request approval from the Department of Health Services (DHS) to disenroll participants who have meet the criteria for involuntary disenrollment identified in IRIS Work Instruction Manual Section 7.1A.1.  Wisconsin State Statute does not require the completion of this form; however, the IRIS program requires the completion of this form to process requests for the involuntary disenrollment of IRIS participants. Personally identifiable information on this form is collected to correctly identify the participant within the IT system, and will be used only for this purpose. | | |
| **SECTION I –DEMOGRAPHICS** | | | | |
| Participant’s Name (Last, First) | | | Participant’s MCI | |
| Target Group  DD  PD  FE | | | Participant’s IRIS Consultant Agency | |
| Date of Last Face-to-Face Contac t | | | Date of Last Attempted Face-to-Face Contact | |
| Date of Last Phone Contact | | | Date of Last Attempted Phone Contact | |
| Reason for Disenrollment | | | | |
|  | No Spend | | | |
|  | No Contact | | | |
|  | Health and Safety | | | |
|  | Residing in an Ineligible Living Setting | | | |
|  | Substantiated Fraud | | | |
|  | Mismanagement of Budget Authority | | | |
|  | Mismanagement of Employer Authority | | | |
|  | Refusal to Comply with IRIS Program Requirements | | | |
| **SECTION II – Reason for Request** | | | | |
| Provide a detailed explanation of the reason for the request. | | | | |
| **SECTION III – Explanation of Attempted Mitigation Strategies** | | | | |
| Provide a detailed explanation of the mitigation strategies implemented to prevent involuntary disenrollment. | | | | |
| **SECTION IV – Conclusion** | | | | |
| Explain why the mitigation strategies were unsuccessful and involuntary disenrollment is the only option. | | | | |
| **SECTION IV – APPLICABLE TO NO CONTACT OR NO SPEND ONLY** | | | | |
| Date ICA Checked For Alternate Contact Information | | | Date ICA Sent Initial Notification of Need for Contact | |
| Date ICA Sent Final Notification of Need for Contact | | | Date of Last IRIS Expenditure | |
| My signature indicates that the information provided above is true and accurate to the best of my knowledge. | | | | |
| **SIGNATURE** – IRIS Consultant Agency Representative | | | | Date Signed |
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