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| **DEPARTMENT OF HEALTH SERVICES**  Division of Medicaid Services  F-01352 (02/2019) | **STATE OF WISCONSIN** | |
| **BACKGROUND CHECK APPEAL REQUEST – IRIS PROGRAM** | | |
| Participants who choose a worker/applicant that does not pass the background check for employment as an IRIS participant-hired worker may request an appeal through the Department of Health Services. The participant and the applicant must complete the information below to request an appeal. | | |
| The completed and signed form must be sent to:  IRIS Background Check Appeals  1 W. Wilson Street, Rm. 518  Madison, WI 53707 | | |
| Completion of this form is voluntary. Both the participant and the applicant must complete their required statements and sign this request for appeal. Personally identifiable information on this form is collected to verify that the request is complete, and will be used only for this purpose. IRIS program representatives will keep your identity confidential. | | |
| **SECTION I – PARTICIPANT INFORMATION** | | |
| Participant’s Name (Last, First)  Last, First | Participant’s MCI  MCI | |
| **SECTION II – APPLICANT INFORMATION** | | |
| Applicant’s Name (Last, First)  Last, First | Applicant’s Date of Birth  Date of Birth | |
| **SECTION III – JOB DUTIES** | | |
| Please list the type and quantity of services the applicant would provide if hired:  Job Duties | | |
| **SECTION IV – SUMMARY OF CONVICTIONS** | | |
| Please list the convictions being appealed including the year convicted, statute number, and specific name: | | |
| Summary of Convictions | | |
| **SECTION V – PARTICIPANT/LEGAL REPRESENTATIVE** | | |
| Please describe in detail why it is important to you that this applicant be allowed to provide you with services and your assessment of your safety with regard to the convictions being appealed: | | |
| Detailed description | | |
| **SECTION VI – APPLICANT** | | |
| Please describe in detail why you think that the convictions you are appealing should be exempt and you should be authorized to be paid with IRIS funds as a participant-hired worker: | | |
| Detailed description | | |
| My signature indicates that the information that I have provided is true and accurate and was provided of my own free will. I acknowledge that I understand that I am not obligated to engage in this appeal process if I would prefer to hire a different participant-hired worker or agency to provide my cares. I understand that I have the option of attempting to hire this applicant through an agency. | | |
| **SIGNATURE** – Participant | | Date Signed |
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| **SIGNATURE** – Guardian or Legal Representative | | Date Signed |
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| My signature indicates that the information provided above is true and accurate to the best of my knowledge. I understand that if I am dissatisfied with the outcome of this appeal that I have the right to file a grievance with the Department of Workforce Development. | | |
| **SIGNATURE** – Applicant | | Date Signed |
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