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| DEPARTMENT OF HEALTH SERVICES  Division of Medicaid Services  F-01569 (08/2020) | |  | | **STATE OF WISCONSIN** | |
| **IRIS CONSULTANT AGENCY (ICA) TRANSFER CHECKLIST** | | | | | |
| Completion of this form is voluntary and is not required by Wisconsin Statutes, but is an IRIS Program requirement necessary for a participant to transfer to a new ICA. The sending ICA shall complete this form and forward it to the receiving ICA and DHS within 10 days of the ADRC signature date on [F-00075](https://www.dhs.wisconsin.gov/forms/f0/f00075.doc) . | | | | | |
| Participant Name | | | Participant MCI | | |
| Participant Name | | | Participant ID Number | | |
| ADRC Signature Date on [F-00075](https://www.dhs.wisconsin.gov/forms/f0/f00075.doc) | Transferring | | | | Effective Date |
| Enter Date | From Enter Sending ICA Name to Receiving ICA Name | | | | Enter Date |
| **PART A:** Important Due Dates (complete all that apply) | | | | | |
| Date Next Medicaid Renewal is Due | | Date Next LTC FS is Due to be Completed | | | |
| Enter Date | | Enter Date | | | |
| Date Next Plan Review is Due | | Date IRIS-SDPC Authorization Expires | | | |
| Enter Date | | Enter Date | | | |
| Other Important Due Date | | | | | |
| Specify Due Date Other Date | | | | | |
| **PART B:** Important information for the receiving ICA. Check all boxes that apply to transferee, over the previous 3 years, unless specified otherwise. | | | | | |
| Adult Protective Services, Adult at Risk, or law enforcement involvement  Substantiated fraud  Critical Incidents  Private duty nursing involvement  Hospice involvement  Use of restrictive measure(s)  Behavior support plan  Conflict of interest present and documented  Notice of Action or State Fair Hearing  Cost share payment concerns or arrearages  Unresolved complaint or grievance  Other – Specify: Enter Text  Please follow up with the IRIS Consultant by phone or email for more details. | | | | | |
| **Part C.** Information Completed By | | | | | |
| **NAME** – Sending ICA Staff Completing Form | | Phone Number | | | |
| Enter Name | | Enter Phone Number | | | |
| Email Address | | | | | |
| Enter Email Address | | | | | |
| **Forward this form to both the receiving ICA and to DHS when complete.**  **IRIS Email:** [DHSWISITSSystemAdmin@dhs.wisconsin.gov](mailto:DHSWISITSSystemAdmin@dhs.wisconsin.gov) | | | | | |