**DEPARTMENT OF HEALTH SERVICES** **STATE OF WISCONSIN**

Division of Medicaid Services

F-02470 (03/2019)

**IRIS NONCOMPLIANCE STATEMENT AND CORRECTIVE ACTION PLAN**

**Use of Form**: This form is used by IRIS quality/contract staff to identify noncompliance or violation(s) of criteria and standards identified in the IRIS Certification Criteria (P-00825 or P-00826), and to outline imposed plans of correction, if applicable. Failure to submit an appropriate correction plan by due date listed below may result in sanctions identified in the IRIS Contract.

**Instructions**: The Noncompliance Statement below identifies incident(s) of noncompliance or violation of the IRIS Certification Criteria identified by the IRIS quality/contract staff and cites specific questions or tasks that must be addressed in the corrective action plan. Complete the section labeled ‘Corrective Action Plan’ by indicating the steps that will be taken to address and correct each of the listed noncompliance(s). Identify expected completion date(s) for each item. Return the original to the [DHSIRISContractCompliance@dhs.wisconsin.gov](mailto:DHSIRISContractCompliance@dhs.wisconsin.gov) and [DHSIRISQuality@dhs.wisconsin.gov](mailto:DHSIRISQuality@dhs.wisconsin.gov) for approval and retain a copy. Attachments can be submitted alongside the completed form, specifying updates to or clarifications of contractor policy, operations, or organization. This request for a corrective action plan is not an order imposing a sanction or penalty, as defined in the IRIS Certification Criteria. If the Department decides to apply a sanction or penalty for facts arising from this finding or a future finding, you will be given a notice of the sanction and/or penalty.

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| Contractor: Contractor  Primary Responsible Contacts: Primary Contact(s) | | Date Corrective Plan Due: Date | Date of Issuance: Date | |
| # | Violation/Contract Citation  Noncompliance Statement | Corrective Action Plan | Expected Completion Date | Verification Date |
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