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| **DEPARTMENT OF HEALTH SERVICES**  Division of Medicaid Services  F-01210B (01/2017) | | | | | **STATE OF WISCONSIN** | | | |
| **IRIS BUDGET AMENDMENT ANNUAL VERIFICATION (BAAV) REQUEST** | | | | | | | | |
| **INSTRUCTIONS:** | Completion of this form is not required through Wisconsin State Statute; however, completion of this form is an IRIS program requirement. The continuation of only one budget amendment may be requested per form. If there are multiple budget amendments in need of continuation, multiple forms must be submitted. Personally identifiable information on this form is collected to verify that the request is complete, and will be used only for this purpose.  See page 2 of this form for detailed instructions. | | | | | | | |
| **SECTION I – DEMOGRAPHICS (ALL FIELDS MUST BE FILLED)** | | | | | | | | |
| Participant’s Name (Last, First) | | | | | Participant’s MCI Number | | | |
| County of Residence | | | | | Date of Birth | | | |
| Target Group | | | | | IRIS Consultant | | | |
| Date Participant Identified Need | | | | | Initial Budget Amendment SharePoint Issue ID Number | | | |
| IRIS Start Date | | | | | Identical to Original Request  Less than Original Request | | | |
| Monthly Individual Budget Estimate Per Most Recent LTC FS | | | | |  | | | |
| **SECTION II – REQUESTED CONTINUATION OF IRIS FUNDED SUPPORT/SERVICE/GOOD** | | | | | | | |
| **Support/Service/Good** | | **Vendor/Provider** | **Units Per Week** | **Rate Per Unit (without and with taxes)** | | **Total Weekly Cost of Budget Amendment (including taxes when applicable)** | **Total Monthly Cost of Budget Amendment (including taxes when applicable)** |
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| **SECTION III - JUSTIFICATION** | | | | | | | | |
| Explain the reason for the continuation of the previously approved budget amendment, including an explanation of changes lending to a request for less than the amount approved in the original budget amendment. | | | | | | | | |
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| **SECTION IV – ADDITIONAL INFORMATION** | | | | | | | | |
| 1. Has the participant’s living situation, including residence or number of people in the household, changed since the previous Budget Amendment Annual Verification was completed?   Yes  No | | | | | | | | |
| If yes, please explain | | | | | | | | |
| 1. Has the participant’s employment status, including starting or discontinuing employment or increase or decreasing hours, changed since the previous Budget Amendment Annual Verification was completed?   Yes  No | | | | | | | | |
| If yes, please explain | | | | | | | | |
| By completing and submitting this form, you are confirming that you have completed all required fields. You further confirm that all information provided has been reviewed, verified and is accurate to the best of your knowledge. | | | | | | | | |
| **SIGNATURE** – Participant | | | | | Date Signed | | | |
| **SIGNATURE** – Legal Representative | | | | | Date Signed | | | |
| **SIGNATURE** – IRIS Consultant | | | | | Date Signed | | | |

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| **Who Should Use This Form**  This form should be used by IRIS participants and IRIS consultant agencies who request a continuation of a previously approved budget amendment. | | | | | | | | |
| **How to Complete This Form**  This form is to be completed and submitted electronically. This document is a fillable Microsoft Word document. TAB or CLICK between fields. One form must be completed for each budget amendment in need of continuation. | | | | | | | | |
| \*\*ALL FIELDS ON THIS FORM ARE REQUIRED. \*\* | | | | | | | | |
| **SECTION I – DEMOGRAPHICS:** | | | | | | | | |
| **Participant’s Name**: Insert Participant’s Name | | | | | **MCI**: Insert Participant’s MCI | | | |
| **County of Residence**: Insert Participant’s County of Residence | | | | | **Date of Birth**: Insert Participant’s Date of Birth | | | |
| **Target Group**: Insert Participant’s Target Group | | | | | **IRIS Consultant**: Insert Name of Participant’s Consultant | | | |
| **Date Participant Identified Need**: Insert the date the participant first informed the consultant of the needed budget amendment. | | | | | **Initial Budget Amendment SharePoint Issue ID number**: Enter the number of the Issue ID in SharePoint (Column 1) | | | |
| **IRIS Start Date**: Enter the participant’s start date in the IRIS program. | | | | | Identical to Original Request  Less than Original Request  Check the applicable box. If the amount of support or service has increased, you must submit a new budget amendment and the use of this form is not appropriate. | | | |
| **Monthly Individual Budget Estimate Per Most Recent LTC FS:** Enter the individual budget estimate calculated by the most recent LTC FS. | | | | |  | | | |
|  | **SECTION II – REQUESTED CONTINUATION OF IRIS FUNDED SUPPORT/SERVICE/GOOD** | | | | | | |
| **Support/Service/Good** | | **Vendor/Provider** | **Units per Week** | **Rate per Unit (without and with taxes)** | | **Total Weekly Cost of Budget Amendment (including taxes when applicable)** | **Total Monthly Cost of Budget Amendment (including taxes when applicable)** |
| Enter the Medicaid Waiver approved support/service/ good that is being requested. This service MUST be an approved service/support/ good in the Medicaid Waiver.  Only one support/service/ good may be requested per form. You may not add additional rows to this section and you may not combine multiple supports/services/goods into one line. | | Enter the name of the provider or vendor who will provide the service/support/ good. Specific names are required. If there are multiple providers, list ALL providers. If the name is unknown at the time of the request, document “unknown at this time” | Enter the number of units per week being requested. | Enter the rate per unit being requested. The ICA must include the unit of measurement.  Ex. Per mile, per hour, per day, per week, per trip, etc.  Hourly rates provided must be written without and with taxes. | | Enter the total weekly cost of the requested budget amendment. This should be calculated through the units per week x rate per unit. | Enter the total monthly cost of the requested budget amendment. This should be the calculated through the total weekly cost of budget amendment x 4.3. |
| **SECTION III – JUSTIFICATION** | | | | | | | | |
| Explain why the support, service, or good is still needed. Include information about how the use of the support, service, or good worked for the participant over the last year. Include information related to requesting a decrease in the level of support, service, or good from the original budget amendment. | | | | | | | | |
| **SECTION IV – ADDITIONAL INFORMATION** | | | | | | | | |
| 1. Check “No” if the participant’s living situation has not changed since the initial budget amendment approval or previous Budget Amendment Annual Verification (BAAV). Check “Yes” if the participant’s living situation has changed since the initial budget amendment approval or previous Budget Amendment Annual Verification (BAAV). If yes, please describe the change. This includes changes both in residence and number of people living in the household. | | | | | | | | |
| 1. Check “No” if the participant’s employment status has not changed since the initial budget amendment or previous Budget Amendment Annual Verification. Check “Yes” if the participant’s employment status has changed since the initial budget amendment request or previous Budget Amendment Annual Verification. If yes, please describe the change. This includes the number of hours worked and starting or discontinuing employment. | | | | | | | | |
| **How to Submit This Form**  The IRIS Consultant must upload this form annually into the Wisconsin Self-Directed Information Technology System for DHS review. | | | | | | | | |