IRIS Provider Paperwork

Provider Forms Examples

- F-01312: IRIS Provider Application
- W-9: Request for Taxpayer Identification Number and Certification
- F-00180C: Wisconsin Medicaid Program Provider Agreement and Acknowledgment of Terms of Participation for Waiver Service Provider Agencies or Individuals
- Vendor Direct Deposit Form
- F-82064: Background Information Disclosure (BID)
- F-01246: Background Information Disclosure Addendum
- Adult Family Home Information
- iLIFE Provider Agreement

Note: The terms "Vendor" and "Provider" may be used interchangeably throughout this document.
**INSTRUCTIONS**

**PROVIDER DEMOGRAPHICS**
- **Organization Name:** The organization name, if applicable.
- **Provider’s Name:** The Provider’s full, legal name in last name, first name, middle initial format.
- **Telephone Number:** The Provider’s telephone number with Area Code.
- **Email Address:** The Provider’s email address.
- **Title:** The Provider’s title, if applicable.
- **Are you applying as:** Check the box that describes the Provider (Agency or Individual Practitioner).

**Type of Application:** Check the box that describes the type of application (Initial Application or Reinstatement).

**W-9 Exempt:** If Provider is W-9 exempt, check “Yes.”

**BILLING AND CLAIMS CONTACT INFORMATION**
- **Check all that apply:** If you use one address for all purposes, check all boxes that apply. Additional Rendering and Daily Operations Information is not needed if you use only one address.

<table>
<thead>
<tr>
<th>National Provider Identifier</th>
<th>Tax Identification Number</th>
<th>Tax Qualifier</th>
<th>Provider Organization Name</th>
<th>Provider Name (Full)</th>
<th>Telephone Number</th>
<th>Email Address</th>
<th>Contact’s Email Address</th>
<th>Fax Number</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Organization Name</td>
<td>Provider Name (Full)</td>
<td>Telephone Number</td>
<td>Email Address</td>
<td>W-9 Exempt:</td>
<td>State of Wisconsin Department of Financial Institutions ID Number:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**RENDERING PROVIDER CONTACT INFORMATION**
- **Check all that apply:**

<table>
<thead>
<tr>
<th>National Provider Identifier</th>
<th>Tax Identification Number</th>
<th>Tax Qualifier</th>
<th>Organization Name</th>
<th>Name – Contact Person</th>
<th>Telephone Number</th>
<th>Email Address</th>
<th>Contact’s Email Address</th>
<th>Fax Number</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Check all that apply:</td>
<td></td>
<td></td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**DAILY OPERATIONS CONTACT INFORMATION**
- **Check all that apply:**

<table>
<thead>
<tr>
<th>National Provider Identifier</th>
<th>Tax Identification Number</th>
<th>Tax Qualifier</th>
<th>Organization Name</th>
<th>Name – Contact Person</th>
<th>Telephone Number</th>
<th>Email Address</th>
<th>Contact’s Email Address</th>
<th>Fax Number</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Check all that apply:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**INSTRUCTIONS**

**SERVICES TO BE PROVIDED**

**Services**: Enter the services the Provider will provide. This information is optional but recommended.

**Does this service require a license or certification?**: Enter "Yes" or "No," as applicable.

**LICENSING/CERTIFICATION**

If licensure/certification is required for the service(s) to be provided, list license/certificate(s) Title, Type, Number, State in which Obtained, and Expiration Date. Each license/certificate required must be listed and attached to the application when submitted.

**Signature – Provider**: The Provider’s signature.

**Date Signed**: The date the form was signed by the Provider.

---

**F-01312**

**Fax Number**: [Insert]

**Internet Address**: [Insert]

**City**: [Insert]

**State**: [Insert]

**Zip Code**: [Insert]

**County**: [Insert]

**SERVICES TO BE PROVIDED**: List the service(s) you wish to provide. Please reference the IRIS Service Definition Manual for a complete list of allowable services.

**Example**: "Supportive Home Care," "Snow Shoveling," etc.

**Does this service require a license or certification?**: Enter "Yes" or "No," as applicable.

**LICENSING/CERTIFICATION**: List all current licenses and certificates (if applicable). A copy of each is required with this application.

<table>
<thead>
<tr>
<th>Title of</th>
<th>Type of</th>
<th>License/Certification Number</th>
<th>State in which Obtained</th>
<th>Expiration Date</th>
</tr>
</thead>
</table>

**IMPORTANT**: If service requires license or certification, licensing information must be listed and attached.

By signing below, I certify that background checks on all employees have been completed in accordance with the Wisconsin Caregiver Program.

If I am to provide specialized transportation, I certify that the vehicle used is and will be mechanically sound, has properly functioning lighting, safety, ventilation, and braking systems, and properly inflated tires without excessive wear. I further certify that proper licensing and insurance has been verified and is attached.

I understand and agree that this application will not be processed until it is deemed complete by DHS. It is my responsibility to provide a complete application. I understand and agree that the burden of producing adequate information in a timely manner and for resolving doubt is my responsibility.

I certify that the information in this document and all attached documents is true, correct, and complete. I understand and agree that any misrepresentation, misstatement, or omission from this application, if discovered after provider approval has been awarded, may lead to suspension or termination of provider approval.

**SIGNATURE**

---

**Provider Signature**: [Insert]

**Date Signed**: mm/dd/yyyy

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**Please submit this application to your Fiscal Employer Agent (FEA) using ONE of the following methods:**

**AGENCY**

<table>
<thead>
<tr>
<th>AGENCY</th>
<th>FAX</th>
<th>EMAIL</th>
<th>GROUND MAIL</th>
</tr>
</thead>
<tbody>
<tr>
<td>GT Independence</td>
<td>888-972-3891</td>
<td><a href="mailto:customerservice@gtindependence.com">customerservice@gtindependence.com</a></td>
<td>215 Broadus St. Sturges, MI 49091</td>
</tr>
<tr>
<td>ILIFE</td>
<td>414-918-4463</td>
<td><a href="mailto:IRIS.Vendor@lIFEFms.com">IRIS.Vendor@lIFEFms.com</a></td>
<td>6100 North Baker Road Glendale, WI 53209</td>
</tr>
<tr>
<td>Outreach Health Services</td>
<td>877-901-5826</td>
<td><a href="mailto:Wisconsin@outreachhealth.com">Wisconsin@outreachhealth.com</a></td>
<td>204 3rd Avenue, Suite 110 P.O. Box 946 Oconomowoc, WI 54020</td>
</tr>
<tr>
<td>Premier Financial Management Services</td>
<td>888-302-3607</td>
<td><a href="mailto:vendorpaperwork@premier-fms.com">vendorpaperwork@premier-fms.com</a></td>
<td>10425 W North Ave, Suite 345 Milwaukee, WI 53226</td>
</tr>
</tbody>
</table>

**Information contained in email messages may be privileged and confidential. There is some risk that any information in an email you send may be disclosed to, or intercepted by, unauthorized third parties. By agreeing to allow the use of email as a method of communication to WI DHS, this indicates that you acknowledge and accept the possible risks associated with such communication.**
INSTRUCTIONS

Box 1: The Provider’s name as it is shown on the person’s tax return.

Box 2: The Provider’s business/organization name (if different from the Provider’s name).

Box 3: Check one box to identify the Provider’s federal tax classification.

Box 4: If exemption codes apply, enter them here.

Box 5: The Provider’s street address.

Box 6: The Provider’s city, state, and ZIP code.

PART I

The Provider’s social security number or employer identification number (EIN), as appropriate. The number used here must match the Tax Identification Number and Tax Qualifier identified on the F-01312, IRIS Provider Application.

PART II

Signature of U.S. person: The Provider’s signature.

Date: The date the Provider signed this form.
INSTRUCTIONS

Name of Provider: The full, legal name of the Provider Agency. The name used here must match the name used on the other application documents.

Phone Number: The Provider Agency’s telephone number with Area Code.

Address – Street, City, State, and ZIP Code: The Provider Agency’s street address, city, state, and ZIP code.

Continued on Page 2

DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
42 CFR 431.107 & 42 CFR 436.802(b)

WISCONSIN MEDICAID PROGRAM PROVIDER AGREEMENT AND ACKNOWLEDGEMENT OF TERMS OF PARTICIPATION
FOR WAIVER SERVICE PROVIDER AGENCIES OR INDIVIDUALS

Completion of this form is required under Federal Law by the Centers for Medicare & Medicaid Services, Department of Health and Human Services, under the Code of Federal Regulations 42 CFR 431.107.

<table>
<thead>
<tr>
<th>Name of Provider (Typed or Printed—Must exactly match name used on all other documents)</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Name (must match other documents)</td>
<td>Provider Street Address</td>
</tr>
<tr>
<td>City</td>
<td>State</td>
</tr>
<tr>
<td>ZIP Code</td>
<td></td>
</tr>
</tbody>
</table>

The above-referenced provider of home and community-based waiver services under Wisconsin’s Medicaid program, hereinafter referred to as the provider, hereby agrees and acknowledges as follows:

1. To provide only the items or services authorized by the managed care organization or IRIS program.
2. To accept the payment issued by the managed care organization or IRIS program as payment in full for provided items or services.
3. To make no additional claims or charges for provided items or services.
4. To refund any overpayment to the managed care organization or IRIS program.
5. To keep any records necessary to disclose the extent of services provided consistent with the provider’s business type.
6. To provide, upon request by the managed care organization, the IRIS program, or the Department of Health Services (DHS) or its designee, information regarding the items or services provided.
7. To comply with all other applicable federal and state laws, regulations, and policies relating to providing home and community-based waiver services under Wisconsin’s Medicaid program including the caregiver background check law.
8. Medicaid Confidentiality Policies and Procedures: To maintain the confidentiality of all records or other information relating to each participant’s status as a waiver participant and items or services the participant receives from the Provider.
9. To respect and comply with the waiver participant’s right to refuse medication and treatment and other rights granted the participant under federal and state law.
10. Medicaid Fraud Prevention Policies and Procedures (including records retention): To keep records necessary to disclose the extent of services provided to waiver participants for a period of ten (10) years and to furnish upon request to the DHS, the federal Department of Health and Human Services, or the state Medicaid Fraud Control Unit, any information regarding services provided and payments claimed by the Provider for furnishing services under the Wisconsin Medicaid Program. This requirement includes retaining all records and documents according to the terms provided by Wis. Admin. Code § DHS 106:02(5)(d) (f)-(g).  
11. The provider agrees to comply with the disclosure requirements of 42 CFR Part 455, Subpart B, as now in effect or as may be amended. To meet those requirements and address real or potential conflict of interest that may influence service provision, among other things the provider shall furnish to the managed care organization and upon request, to the Department in writing:
   a) The names and addresses of all vendors of drugs, medical supplies or transportation, or other providers in which it has a controlling interest or ownership;
   b) The names and addresses of all persons who have a controlling interest in the provider;
INSTRUCTIONS

Name – Provider: The Provider Agency's name.

Signature – Provider: The Provider Agency Representative's signature.

Date Signed: The date this form was signed by the Provider Agency Representative.

NAME – Provider (Typed or Printed)

Provider Name

SIGNATURE – Provider

Provider Agency Representative's Signature

mm/dd/yyyy

FOR DMS USE ONLY (DO NOT WRITE BELOW THIS LINE)

SIGNATURE – Department of Health Services

Date Signed

8/14/17
Vendor Direct Deposit Authorization

Instructions: 1. Vendor completes all information and signs at the bottom.
   2. Attach a voided check or typed bank verification with the account and routing
      numbers and account holder’s name.

   NOTE: To be effective for the pay date, submit this form at least five business days
   before the pay date.

Vendor Name: Provider Name

Address: Provider Street Address, City, State, and ZIP Code

Tax Identification Number (EIN or Last Four Digits of SSN): Provider’s tax ID number. The
   identifier used here must match the one used on the F-01312, IRIS Provider Application and the W-9,
   Request for Taxpayer Identification Number and Certification.

Contact Name: Provider’s contact’s name (if different than the Provider name).

Contact Phone Number: Provider’s contact phone number.

Name of Financial Institution: The name of the financial institution
   affiliated with the checking or savings account to be used for direct deposit.

Routing Number: The routing number of the account to be used.

Account Number: The account number of the account to be used.

Type of Account: Check one option (Checking or Savings), and attach
   the documentation required for that type of account.

Vendor Signature: Provider’s signature.

Date: The date the Provider signed this form.

IMPORTANT:
A voided check or typed bank verification with the account and routing
numbers and account holder’s name must be attached.
EXAMPLE: F-82064
Background Information Disclosure
Page 1

INSTRUCTIONS

Check the box that applies to you: Check “Other – Specify” and write “Vendor.”

Full Legal Name – (First and Middle): The Provider’s first name and middle name.

Legal Name – (Last): The Provider’s last name.

Birth Date: The Provider’s birth date.

Sex: Check the box that best describes the Provider’s sex.

Any Other Names…: Include any names that the Provider has been known by – including maiden name.

Race/Ethnicity: Check the box that best describes the Provider’s race.

Social Security Number: The Provider’s social security number.

Home Address, City, State, and ZIP Code: Enter the Provider’s street address, city, state, and ZIP code.

Business Name and Address: The Provider’s business name and address (street address, city, state, and ZIP code).

SECTION A

For each question, check either “Yes” or “No.” Note: Some questions require additional information. Please read carefully.

NOTE:
This form required only for Individual Practitioners (Agency of One).
### INSTRUCTIONS

**SECTION A (continued)**

For each question, check either “Yes” or “No.” Note: Some questions require additional information. Please read carefully.

**SECTION B**

For each question, check either “Yes” or “No.” Note: Some questions require additional information. Please read carefully.

**Read and initial the following statement:** The Provider’s initials.

**Name – The Person Completing This Form:** The Provider’s name.

**Date Signed:** The date this form was signed by the Provider.

---

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Has any government or regulatory agency (other than the police) ever found that you abused or neglected any person or client? If Yes, explain, including when and where it happened.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Has any government or regulatory agency (other than the police) ever found that you misappropriated (improperly took or used) the property of a person or client? If Yes, explain, including when and where it happened.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Has any government or regulatory agency (other than the police) ever found that you <strong>abused an elderly person</strong>? If Yes, explain, including when and where it happened.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Do you have a government issued credential that is not current or is limited so as to restrict you from providing care to clients? If Yes, explain, including credential name, limitations or restrictions, and time period.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**SECTION B – OTHER REQUIRED INFORMATION**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Has any government or regulatory agency ever limited, denied, or revoked your license, certification, or registration to provide care, treatment, or educational services? If Yes, explain, including when and where it happened.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Has any government or regulatory agency ever denied you permission or restricted your ability to live on the premises of a care providing facility? If Yes, explain, including when and where it happened and the reason.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Have you been discharged from a branch of the US Armed Forces, including any reserve component? If Yes, indicate the year of discharge: ____ Attach a copy of your DD214, if you were discharged within the last three (3) years.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Have you resided outside of Wisconsin in the last three (3) years? If Yes, list each state and the dates you resided there.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. If you are employed by or applying for the State of Wisconsin, have you resided outside of Wisconsin in the last seven (7) years? If Yes, list each state and the dates you resided there.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Have you had a caregiver background check done within the last four (4) years? If Yes, list the date of each check, and the name, address, and phone number of the person, facility, or government agency that conducted each check.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Have you ever requested a rehabilitation review with the Wisconsin Department of Health Services, a county department, a private child placing agency, school board, or DHS-designated tribe? If Yes, list the review date and the review result. You may be asked to provide a copy of the review decision.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Read and initial the following statement.**

**Initials** I have completed and reviewed this form (F-82064, BID) and affirm that the information is true and correct as of today’s date.

**Name – Person Completing This Form**

**Provider Name**

**Date Submitted** mm/dd/yyyy

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**NOTE:**

This form required only for Individual Practitioners (Agency of One).
# Background Information Disclosure Addendum

**INSTRUCTIONS**

**SECTION I**
**Name:** The Provider’s name in last name, first name, middle initial format.

**Date of Birth:** The Provider’s birthdate in mm/dd/yyyy format.

**Address, Years at Residence, and Any Other Names:** For the past 3 years, list:
- The Provider’s Address (street address, city, state, and ZIP code)
- The number of years at that residence
- Any other names that the Provider went by while at that location

**Report for each prior address until the total years at residence listed is equal to at least 3 years.**

**SECTION II**
If the Provider has lived outside of Wisconsin in the past 3 years, this section will need to be completed. If the Provider has NOT lived outside of Wisconsin for the past 3 years, skip to the Signature and Date Signed fields.

Section II includes:
- Current Address/Previous Address, City, State, ZIP Code, and County: For the past 3 years, list:
  - The Provider’s address (street address, city, state, and ZIP code)
  - Repeat for each prior address until the total years at residence listed is equal to at least 3 years.
- Mother’s Maiden Name: The Provider’s mother’s maiden name.
- Mother’s Current Name: The Provider’s mother’s current name in last name, first name, middle initial format.
- Father’s Name: The Provider’s name in last name, first name, middle initial format.

**Signature:** The Provider’s signature.

**Date Signed:** The date this form was signed by the Provider.

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**EXAMPLE: F-01246**

**BACKGROUND INFORMATION DISCLOSURE ADDENDUM—IRIS**

**INSTRUCTIONS:** Completion of this form is required under the provisions of Chapters 48.685 and 50.065 Wis. Stats. Failure to comply may result in a denial or termination of your employment.

Personally identifiable information on this form is collected to verify your identity and that the form is complete.

**SECTION I — APPLICANT INFORMATION**

<table>
<thead>
<tr>
<th>Name – (Last, First, Mi)</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider’s Last Name, First Name, Middle Initial</td>
<td>mm/dd/yyyy</td>
</tr>
</tbody>
</table>

Please list all the cities and states in which you have lived in the past three years, and the name by which you were known (if different from your name now). Please indicate the number of years you lived there.

<table>
<thead>
<tr>
<th>Address – (Address, City, State, Zip Code)</th>
<th>Years at Residence</th>
<th>Any Other Names By Which You Have Been Known (Including Maiden Name)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider’s Street Address, City, State, and ZIP Code</td>
<td>#</td>
<td>Any other names the Provider has used.</td>
</tr>
</tbody>
</table>

**SECTION II — ADDITIONAL APPLICANT INFORMATION**

Completion of this section is only required for applicants who have lived outside the state of Wisconsin in the past three years.

<table>
<thead>
<tr>
<th>Current Address</th>
<th>Provider’s Current Address</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>County</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous Address</td>
<td>Provider’s Previous Address</td>
<td>City</td>
<td>State</td>
<td>Zip Code</td>
<td>County</td>
</tr>
</tbody>
</table>

Mother’s Maiden Name

Provider’s Mother’s Maiden Name

Mother’s Current Name – (Last, First, Mi)

Provider’s Father’s Name in Last Name, First Name, Middle Initial Format

I acknowledge that the information on this form is accurate to the best of my knowledge. By signing below, I agree to have a background check run.

I further acknowledge that an out-of-state background check may increase processing time, if applicable.

**SIGNATURE – Applicant**

Provider Signature

**Date Signed**

mm/dd/yyyy

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**NOTE:**

This form required only for Individual Practitioners (Agency of One).
INSTRUCTIONS
Note: Adult Family Home may be abbreviated as AFH throughout this form.

Name of Adult Family Home:
The AFH's name.

Address, City, State, ZIP: The AFH's street address, city, state, and ZIP code.

Contact Person: The AFH contact person's name.

Phone Number: The contact person's telephone number.

Email Address: The contact person's email address.

Questions 1 through 6: Check the appropriate box to answer each question, and supply additional information as necessary.

AFH Contact Signature: The signature of the AFH contact person named above.

Date: The date the AFH contact person signed this form.

NOTE: This form only required for Adult Family Homes.
Provider Agreement

Instructions: 1. Participant completes the top, and provider completes the bottom.
2. Participant and provider sign at the bottom.

Participant Name _______________ (Participant), hereafter referred to as Participant, and
Provider Name _______________ (Provider), hereafter referred to as Provider, do hereby enter into the
following agreement:

The Participant requires the following tasks and duties to be performed by the Provider:

Example: “Supportive home care (SHC) and snow shoveling”

The Provider agrees to provide/arrange for training as described below:

Example: “Provider will receive a schedule of my daily living activities.”

The Provider agrees to perform the tasks as outlined above according to the following schedule:

- Monday
- Tuesday
- Wednesday
- Thursday
- Friday
- Saturday
- Sunday

Other: ____________________________

Services will be provided at the rate of $ __________ per __________ (Hour, Day, Week, One Time).

The Participant and Provider understand that these services are provided under Medicaid regulations and
that we may not charge in excess of the amount agreed upon with this document.

After the Provider has performed the services per this agreement, claims are due to ILIFE per the ILIFE Provider Payment Schedule.

Provider FEIN: Provider Federal Employer Identification Number (EIN)

Name: __________________________

Address: __________________________

City: __________________________ State: WI Zip: __________________________

Phone: __________________________

Provider Signature: __________________________

Date Signed: __________________________

Participant or Guardian Signature: __________________________ Date: __________________________

Date Signed: __________________________

INSTRUCTIONS

PAGE 1

( Participant): The Participant’s name in first name, last name format.

( Provider): The Provider’s name. If individual Provider, use first name, last name format.

The Participant requires...: Enter the tasks the provider will provide.

The Provider agrees...: Enter the training the Participant/Employer will provide for the Provider (if any).

Provider schedule: Check the days of the week the Provider will be providing services or enter an explanation of the schedule in the “Other” field.

Services will be provided at the rate of ...: Enter a dollar amount and check one box to indicate the rate of pay for the service(s) to be provided.

Provider FEIN: The Provider’s Federal Employer Identification Number (EIN).

Name: The Provider’s name.

Address, City, State, and ZIP: The Provider’s street address, city, state, and ZIP code.

Phone: The Provider’s telephone number.

Provider Signature: The Provider’s signature.

Date Signed: The date the Provider signed this form.

Participant or Guardian Signature: The date the Participant/Employer (or his/her representative) signed this form.

Date Signed: The date the Participant/Employer (or his/her representative) signed this form.