iLIFE
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IRIS Vendor-Provider Paperwork

Vendor-Provider Forms Instructions And Samples

Contents

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

Updated: 12/22/22

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.

Phone Number: The Provider's phone 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.

National Provider Identifier: The Provider's National Provider ID, if applicable.

Tax Identification Number: The Provider's tax ID number.

Tax Qualifier: The Provider's tax ID number qualifier.

Organization Name: The Provider's organization's name, if applicable.

Name – Contact Person: The Provider's contact person's name.

Phone Number: The person's phone number with Area Code.

Email Address: The person's email address.

Fax Number: The person's fax number.

Address, City, State, Zip Code, and County: The Provider's street address, city, state, ZIP code, and county.

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DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-01312 (12/2022)

STATE OF WISCONSIN

IRIS PROVIDER APPLICATION

INSTRUCTIONS: Completion of this form is not required through Wisconsin State Statute; however, completion of this form is an IRIS program requirement. Applicants will not be considered as IRIS program service providers until all necessary paperwork is completed, submitted, and verified.

Agency Provider is defined as entities whose employees furnish the service or from which goods are purchased. Individual Provider is defined as a person who is in an independent practice and not employed by a provider agency.

Personally identifiable information on this form is collected to verify that the application is complete and accurate, and will be used only for this purpose.

PROVIDER DEMOGRAPHICS

Organization Name: **Provider Organization Name**

Provider's Name (Last, First, MI)	Phone Number	Email Address ☐ *May be published in Provider Directory*
Provider Name (Full)	**Phone Number**	**Email Address**

Title: **Provider Title**

Are you applying as (choose one): ☑ Agency Provider ☐ Individual Provider

Type of Application: ☑ Initial Application ☐ Reinstatement

W-9 Name (as shown on income tax return)	W-9 Business Name (if different from W-9 name)
W-9 Exempt: ☐ Yes ☑ No	State of Wisconsin Department of Financial Institutions ID Number:

BILLING AND CLAIMS CONTACT INFORMATION

Check all that apply: ☑ Primary Office ☑ Mailing Address ☑ Billing Address

National Provider Identifier (if applicable): **National Provider Identifier**	Wisconsin Provider Management Identifier (if applicable):
Tax Identification Number: **Tax Identification Number**	Tax Qualifier: ☐ EIN ☐ SSN

Organization Name: **Provider Organization Name**

Name – Contact Person	Phone Number	Email Address ☐ *May be published in Provider Directory*
Contact Name	**Phone Number**	**Contact's Email Address**
Fax Number: **Contact's Fax Number**		Internet Address ☐ *May be published in Provider Directory*

Address	City	State	Zip Code	County
Provider's Business Address	**City**	**State**	**Zip Code**	**County**

RENDERING PROVIDER CONTACT INFORMATION

Check all that apply: ☐ Primary Office ☐ Mailing Address ☐ Billing Address

National Provider Identifier (if applicable):	Wisconsin Provider Management Identifier (if applicable):
Tax Identification Number:	Tax Qualifier: ☐ EIN ☐ SSN

Organization Name

Name – Contact Person	Phone Number	Email Address ☐ *May be published in Provider Directory*
Fax Number		Internet Address ☐ *May be published in Provider Directory*

Address	City	State	Zip Code	County

DAILY OPERATIONS CONTACT INFORMATION

Check all that apply: ☐ Primary Office ☐ Mailing Address ☐ Billing Address

National Provider Identifier (if applicable):	Wisconsin Provider Management Identifier (if applicable):
Tax Identification Number:	Tax Qualifier: ☐ EIN ☐ SSN

Organization Name

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 (12/2022) Page **2** of **2**

Name – Contact Person	Telephone Number	Email Address ☐ *May be published in Provider Directory*		
Fax Number		Internet Address ☐ *May be published in Provider Directory*		
Address	City	State	Zip Code	County

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.

Services	Does this service require a license or certification?
Example: ***"Supportive Home Care," "Snow Shoveling," etc.***	**Example:** ***"No"***

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

				State in which

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 doubts 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	Date Signed
Provider Signature	**mm/dd/yyyy**

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

AGENCY	FAX	EMAIL	GROUND MAIL
GT Independence	888-972-3891	customerservice@gtindependence.com	215 Broadus St. Sturgis, MI 49091
iLIFE	414-918-4463	IRIS.Vendor@iLIFE.org	2020 W Wells St Milwaukee, WI 53233
Outreach Health Services	877-901-5826	outreach.wi@outreachfiscalagent.com	204 3rd Avenue, Suite 110 P.O. Box 945 Osceola, WI 54020
Premier Financial Management Services	888-302-3607	vendorpaperwork@premier-fms.com	10425 W North Ave, Suite 345 Milwaukee, WI 53226

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.

EXAMPLE: W-9
Request for Taxpayer Identification Number and Certification

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.

Form **W-9**
(Rev. March 2024)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Go to *www.irs.gov/FormW9* for instructions and the latest information.

Give form to the requester. Do not send to the IRS.

Before you begin. For guidance related to the purpose of Form W-9, see *Purpose of Form*, below.

Print or type. See *Specific Instructions* on page 3.

1 Name of entity/individual. An entry is required. (For a sole proprietor or disregarded entity, enter the owner's name on line 1, and enter the business/disregarded entity's name on line 2.)
Provider Name (as shown on tax return) Organization/

2 Business name/disregarded entity name, if different from above.
Business Name (if different than above)

3a Check the appropriate box for federal tax classification of the entity/individual whose name is entered on line 1. Check only **one** of the following seven boxes.

☑ Individual/sole proprietor ☐ C corporation ☐ S corporation ☐ Partnership ☐ Trust/estate

☐ LLC. Enter the tax classification (C = C corporation, S = S corporation, P = Partnership) . . . . .

Note: Check the "LLC" box above and, in the entry space, enter the appropriate code (C, S, or P) for the tax classification of the LLC, unless it is a disregarded entity. A disregarded entity should instead check the appropriate box for the tax classification of its owner.

☐ Other (see instructions)

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any)

Exemption from Foreign Account Tax Compliance Act (FATCA) reporting code (if any)

(Applies to accounts maintained outside the United States.)

3b If on line 3a you checked "Partnership" or "Trust/estate," or checked "LLC" and entered "P" as its tax classification, and you are providing this form to a partnership, trust, or estate in which you have an ownership interest, check this box if you have any foreign partners, owners, or beneficiaries. See instructions . . . . . ☐

5 Address (number, street, and apt. or suite no.). See instructions.
Street Address

Requester's name and address (optional)

6 City, state, and ZIP code
City, State and ZIP Code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Note: If the account is in more than one name, see the instructions for line 1. See also *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number
– # # – # # #

or

Employer identification number
–

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and, generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here Signature of U.S. person **Provider Signature** Date **mm/dd/yyyy**

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9*.

What's New

Line 3a has been modified to clarify how a disregarded entity completes this line. An LLC that is a disregarded entity should check the appropriate box for the tax classification of its owner. Otherwise, it should check the "LLC" box and enter its appropriate tax classification.

New line 3b has been added to this form. A flow-through entity is required to complete this line to indicate that it has direct or indirect foreign partners, owners, or beneficiaries when it provides the Form W-9 to another flow-through entity in which it has an ownership interest. This change is intended to provide a flow-through entity with information regarding the status of its indirect foreign partners, owners, or beneficiaries, so that it can satisfy any applicable reporting requirements. For example, a partnership that has any indirect foreign partners may be required to complete Schedules K-2 and K-3. See the Partnership Instructions for Schedules K-2 and K-3 (Form 1065).

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS is giving you this form because they

INSTRUCTIONS

Note: All eight pages of this agreement must be returned together.

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.

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

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

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

Wisconsin that are applicable to, or required by, the staff member's duties. Upon request, the provider will supply any applicable documentation to DHS.

o. Provider ensures staff working with frail elders or disabled populations have documented experience with the population that the staff will work with or provider has plans to ensure staff is adequately trained.

p. Provider maintains a training plan for each staff member who provides or will provide direct care to members or participants and has a mechanism for ensuring that all necessary training has been completed prior to performing work and that completion of all trainings is documented.

q. Provider will maintain documentation that staff is trained annually on compliance, fraud, waste, and abuse.

r. Provider ensures staff are trained on DHS recording and reporting requirements for documentation, critical incident reporting, and other information and procedures necessary for the staff to ensure the health and safety of members and participants receiving supports. The applicable requirements are documented in the Family Care Contract, Family Care Partnership, and PACE: Managed Care Organization Contracts and the IRIS (Include, Respect, I Self-Direct) Support Services Provider Training Standards, P-03071.

s. Provider ensures staff are trained on the needs of the target group they are serving.

t. Provider ensures staff are trained on the provision of the services being provided.

u. As applicable, provider ensures staff have been trained or will be trained on the needs, strengths, and preferences of the individual(s) being served, prior to providing direct care.

v. Provider ensures all staff are trained on rights and privacy provisions applicable to providers, members, and participants in Wisconsin, including rights and privacy provisions guaranteed under HIPAA, Wis. Stat. ch. 146, and the Family Care Contract, Family Care Partnership, and PACE: Managed Care Organization Contracts and the IRIS (Include, Respect, I Self-Direct) Support Services Provider Training Standards.

w. Provider will refrain from influencing an individual to either not enroll in or to disenroll from another MCO or the IRIS program.

By signature, the provider or authorized representative swears or affirms under penalty of perjury that the information given in this agreement is true and accurate. By signature, the provider certifies that they have read the LTC Waiver Provider Online Handbook and all regulations.

Name – Provider	
Provider Name	
NPI	Medicaid-Assigned Provider ID
Address (This is the provider's practice location address.)	
Street Address Line 1 **Provider Street Address**	
Street Address Line 2	
City **City** State **State** ZIP+4 Code **Zip Code**	
SIGNATURE – Provider or Authorized Representative	Date Signed
Provider Signature	**mm/dd/yyyy**

EXAMPLE:
iLIFE IRIS Vendor Direct Deposit Form

INSTRUCTIONS

Vendor Name: The Provider's name. Name must match the name on the account, whether an Individual Practitioner or Agency.

Address: The Provider's street address, city, state, and ZIP code.

Tax Identification Number (EIN or Last Four Digits of SSN): The 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: The Provider's contact's name (if different than the Provider name).

Contact Phone Number: The 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: The Provider's signature.

Date: The date the Provider signed this form.

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IRIS 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): **####**

Contact Name: **Provider Contact Name**

Contact Phone Number: **Provider Phone Number**

Name of Financial Institution: **Provider Bank or Credit Union Name**

Routing Number: **#########**

Account Number: **##########**

Type of Account	Required Documents
☑ Checking	Attach either a voided check or a letter from the bank. • Must have the account holder's name, routing and account numbers for the account. • Must be typed. • Starter checks may not be used. • Letter must be printed on bank letterhead.
☐ Savings	Attach a letter from the bank. • Must have the account holder's name, routing and account numbers for the account. • Must be typed. • Must be printed on bank letterhead.

As an authorized representative of the Vendor Name listed above, I hereby authorize iLIFE to initiate credit entries and to initiate, if necessary, debit entries and adjustments for any credit entries in error to my bank account at the financial institution noted above.

This authorization is to remain in full force and effect until iLIFE receives written notice from me of its termination, in such time and manner as to allow iLIFE and the financial institution a reasonable opportunity to act on it.

Vendor Signature: **Provider Signature** Date: **mm/dd/yyyy**

P.O. Box 80439 | Milwaukee, WI 53208 | Phone: 1-888-800-5599 | Fax: 1-414-918-4463
Email: IRIS.Vendor@iLIFE.org | Website: iLIFE.org

(9/2022)

IMPORTANT:
A voided check or typed bank verification with the account and routing numbers and account holder's name must be attached.

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.

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

Birth Date: The Provider's birth date.

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

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.*

Continued on Page 2

DEPARTMENT OF HEALTH SERVICES
Division of Quality Assurance
F-82064 (01/2022)

STATE OF WISCONSIN
Wis. Stat. § 50.065
Wis. Admin. Code § DHS 12.05(4)
Page 1 of 2

BACKGROUND INFORMATION DISCLOSURE (BID) FOR ENTITY EMPLOYEES AND CONTRACTORS

- **PENALTY:** A person who provides false information on this form may be subject to forfeiture and sanctions, as provided in Wis. Stat. § 50.065(6)(c) and Wis. Admin Code § DHS 12.05(4).
- Completion of this form to verify your eligibility for employment/service as a "caregiver" is required by Wis. Stat. § 50.065 and Wis. Admin Code ch. DHS 12. Failure to complete this form may result in denial or termination of your employment, contract or service agreement.

Refer to DQA form F-82064A, *Instructions*, for additional information. **Reset**

Check the box that applies to you.

☐ Applicant / Employee ☐ Student / Volunteer
☐ Contractor ☐ Other – Specify: **Vendor**

NOTE: This form should NOT be used by applicants for *entity operator approval* (license, certification, registration or other DHS approval) or by entities requesting approval for an individual to reside in entity facilities as a *non-client resident*. Applicants for *entity operator approval* or for a *non-client resident* background check must request an *entity* background check from the Division of Quality Assurance.

Full Legal Name – *First*	*Middle*	*Last*
Provider Name (First)	**Provider Name (Middle)**	**Provider Name (Last)**

Other Names (including prior to marriage)
Alternative Provider Names (including Maiden Name)

Position Title (applied for or existing)	Birth Date *(MM/DD/YYYY)*	Sex
	mm/dd/yyyy	☑ Male ☐ Female

Home Address	City	State	Zip Code
Provider Home Street Address	**City**	**State**	**ZIP Code**

Business Name and Address – Employer (Entity)
Provider Business Name and Street Address, City, State, and ZIP Code (if different than home address)

Answering "NO" to all questions does not guarantee employment, a contract, or service agreement.
If more space is required, attach additional documentation to this form and indicate "see attached" in your answer.

SECTION A – DISCLOSURES

		Yes	No
1.	Do you have any criminal charges pending against you, including in federal, state, local, military, and tribal courts? If **Yes**, list each charge, when it occurred or the date of the charge, and the city and state where the court is located. You may be asked to supply additional information, including a copy of the criminal complaint or any other relevant court or police documents.	☐	☐
2.	Were you ever convicted of any crime anywhere, including in federal, state, local, military, and tribal courts? If **Yes**, list each crime, when it occurred or the date of the conviction, and the city and state where the court is located. You may be asked to supply additional information including a certified copy of the judgment of conviction, a copy of the criminal complaint, or any other relevant court or police documents.	☐	☐
3.	Please note that Wis. Stat. § 48.981, *Abused or neglected children and abused unborn children*, may apply to information concerning findings of child abuse and neglect. Has any government or regulatory agency (other than the police) ever found that you committed **child** abuse or neglect? Provide an explanation below, including when and where the incident(s) occurred.	☐	☐
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.	☐	☐

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.

		Yes	No
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.	☐	☐
6.	Has any government or regulatory agency (other than the police) ever found that you abused an **elderly person**? If **Yes**, explain, including when and where it happened.	☐	☐
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.	☐	☐

SECTION B – OTHER REQUIRED INFORMATION

		Yes	No
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.	☐	☐
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.	☐	☐
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.	☐	☐
4.	Have you resided outside of Wisconsin in the last three (3) years? If **Yes**, list each state and the dates you resided there.	☐	☐
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.	☐	☐
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.	☐	☐
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.	☐	☐

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	Date Submitted
Provider Name	**mm/dd/yyyy**

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

EXAMPLE: F-01246
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.

DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-01246 (02/2017)

STATE OF WISCONSIN
Wisconsin Statutes
§ 48.685 and 50.065
Administrative Rule
DHS 12.05(4)

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

Name – (Last, First, MI)	Date of Birth
Provider's Last Name, First Name, Middle Initial	**mm/dd/yyyy**

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.

Address – (Address, City, State, Zip Code)	Years at Residence	Any Other Names By Which You Have Been Known (Including Maiden Name)
Provider's Street Address, City, State, and ZIP Code	**#**	**Any other names the Provider has used.**

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.

Current Address	City	State	Zip Code	County
Provider's Current Address	**City**	**State**	**ZIP Code**	**County**
Previous Address	City	State	Zip Code	County
Provider's Previous Address	**City**	**State**	**ZIP Code**	**County**
Previous Address	City	State	Zip Code	County
Previous Address	City	State	Zip Code	County

Mother's Maiden Name	Mother's Current Name – (Last, First, MI)
Provider's Mother's Maiden Name	**Providers Mother's Current Name in Last Name, First Name, Middle Initial Format**

Father's 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	Date Signed
Provider Signature	**mm/dd/yyyy**

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

EXAMPLE:
IRIS Adult Family Home Information

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.

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IRIS Adult Family Home Information

REQUIRED FOR AFH PROVIDERS

Instructions: 1. Complete only if providing Adult Family Home (AFH) services.
2. AFH Contact Person signs at the bottom.
3. **Attach a copy of your current AFH Certificate or your extension letter from the State of Wisconsin. Failure to do so may delay payment.**

Name of Adult Family Home: **Name of AFH**

Address: **AFH Street Address**

City: **City** State: **State** Zip: **#####**

Contact Person: **AFH Contact Name**

Phone Number: (**###**) **###** - **####**

Email Address: **AFH Contact Email Address**

According to § 131 of the IRS tax code, certain foster care payments are not taxable as income. The purpose of this form is to assist iLIFE in determining whether this is the case. If it appears that you qualify, you have the option of requesting that a 1099, or equivalent form, not be prepared at year end by iLIFE for you. However you are responsible for determining whether payments made to you are taxable or not, and paying the taxes on that income if it is taxable. iLIFE will not be held responsible for any taxes, interest or penalties on income paid to you.

Please answer all of the questions noted below or the form will be returned to you. If you do not complete this form or if iLIFE does not receive this form, you may be issued a 1099 at year end. Even if you are issued a 1099 form, it is up to you and your tax advisor to determine if the amount needs to be claimed as taxable income.

1. Are you subject to back-up withholding?
   - ☐ Yes
   - ☐ No
2. How is your business organized?
   - ☐ Individual/Sole Proprietor
   - ☐ Corporation
   - ☐ Partnership
   - ☐ LLC
   - ☐ Other, please specify: _____
3. Is the Adult Family Home also your primary home?
   - ☐ Yes
   - ☐ No
4. Number of adult clients, please specify number _____
5. Do you provide respite care?
   - ☐ Yes
   - ☐ No
6. I am requesting that iLIFE not issue a 1099-Misc, or equivalent form, as my Adult Living Facility is exempt from state and federal taxes.
   - ☐ Yes
   - ☐ No

I have read and understand the information on this sheet. To the best of my knowledge, the answers that I have provided above are true and correct. I understand that I solely am responsible for determining the taxability and reporting of income. iLIFE will not be held responsible for any taxes, interest or penalties on income paid to me.

AFH Contact Signature: **AFH Contact Signature** Date: **mm/dd/yyyy**

P.O. Box 80439 | Milwaukee, WI 53208 | Phone: 1-888-800-5599 | Fax: 1-414-918-4463
Email: IRIS.Vendor@iLIFE.org | Website: iLIFE.org

(9/2022)

NOTE:
This form only required for Adult Family Homes.

EXAMPLE:
iLIFE IRIS Provider Agreement

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.

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IRIS Provider Agreement

OPTIONAL

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: **Provider Name**

Address: **Provider Address**

City: **City** State: **WI** Zip: **ZIP Code**

Phone: **# # #** - **# # #** - **# # # #**

Provider Signature: **Provider Signature** Date: **mm/dd/yyyy**

Participant or Guardian Signature: **Participant Signature** Date: **mm/dd/yyyy**

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