WRAPAROUND MILWAUKEE

DISENROLLMENT CONFIRMATION FORM

(Wraparound, REACH and O'YEAH)

Participant Name: ____ DOB: ______________________________

Name of Parent or Guardian (if Participant under 18): ______________________________

Disenrollment Date: ________________

Care Coordination Agency: ____

I understand that I am being disenrolled from Wraparound Milwaukee on the date listed above. I am aware that my enrollment in the Wraparound HMO will also expire on that date. I am aware that care coordination/transition specialist services will no longer be provided as of my disenrollment date, and that Wraparound Milwaukee will no longer be the payor source for behavioral health or alcohol- or drug-related services after my disenrollment date.

If I was covered by Title 19 prior to my enrollment in Wraparound Milwaukee, I understand that I will be re-enrolled in the Title 19 program in which I was previously enrolled (HMO or straight T19). I understand that payments for any continuing behavioral health and alcohol- or drug-related services will be paid for through that T19 program. My care coordinator/transition specialist has worked with me to ensure that any current service providers are aware of this change.

I have received a copy of my final Plan of Care/Futures Plan and acknowledge that a representative of Wraparound Milwaukee may make a follow-up courtesy call to me after disenrollment.

____ ____________ ______________________________________

(Participant Signature) (Date) (Participant Phone Number)

____ ____________ ______________________________________

(Parent/Guardian Signature, required if participant is under the age of 18) (Date) (Parent/Guardian Phone Number)

CONTINUING SERVICES: (list person/agency name, contact information including phone number and appointment dates, if any):

____

____

____

____

RESOURCES:

Families United, Inc. …………………......... 344-7777
Mobile Urgent Treatment Team…………... 257-7621
Badger Care (T19 enrollment)….…….. 800-362-3002
IMPACT (Resource & Referral)………………… 211
Other:____

M.O.V.E WI (Youth Group)………………..….977-4249
Adult Crisis Services………………………….. 257-7222
O'YEAH Program…………………….………. 257-7158
Owen's Place (Resource Center)…..………….. 977-4249
Other:____

REASON FOR DISENROLLMENT:

____ Program completed
WRAPAROUND ONLY:
____Order expired/revised
____ Moved out of county
____ Services no longer desired
WRAPAROUND ONLY:
____Order expired/revised
____ No contact
____ Missing more than 30 days

____ Program transfer
____to Wraparound
____to REACH
____to O'YEAH
____ Referred to CARS/Adult Disability Services
____ Placed in corrections
____check if correctional placement is in MCAP
____ Referred to DMCPS (REACH only)

____ Other (explain):____

______________________________________ __________ ______________________________________ __________

(Care/Transition Coordinator Signature) (Date) (Supervisor/Lead Signature) (Date)

Disenrollment Reviewed and Approved by:

____ ______________________________________

Wraparound Program Staff Date