WRAPAROUND MILWAUKEE
DISENROLLMENT CONFIRMATION FORM

Participant Name: ______________________ DOB: ______________________

Parent/Guardian Name
(if Participant under 18): ______________________ Disenrollment Date: ______________________

Care Coordinator Name: ______________________ 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 coordination 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 coordinator 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 18 year old) Date Parent/Guardian Phone Number

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

Resource & Referral Line	257-7607
Children Mobile Crisis 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
Owen's Place (Resource Center)	977-4249
Other	

REASON FOR DISENROLLMENT:

☐Program completed
WRAPAROUND/REACH CT ORDER ONLY: ☐Order expired/revised
☐Moved out of county
☐Services no longer desired
WRAPAROUND/REACH CT ORDER ONLY: ☐Order expired/revised
☐Unable to Contact
☐Missing more than 30 days
☐Medicaid Eligibility Ended
☐Other (explain):____

☐Program transfer:
☐to O-YEAH
☐to CORE
☐Disenrolled to CCS
☐Disenrolled to Adult Programming
☐Placed in corrections
☐ Long-term Residential

______________________________ ______________________________
Care/Transition Coordinator Signature Date Supervisor/Lead Signature Date

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Disenrollment Reviewed and Approved by:

Wraparound Program Staff Signature______________________________ Date______________________