



Milwaukee County DHHS-BHD
Children's Community Mental Health Services and Wraparound Milwaukee

DISENROLLMENT CONFIRMATION FORM

Enrollee's Name: _____

Date of Birth: _____

Parent/Guardian Name
(if 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 services will no longer be provided, and that Wraparound Milwaukee will no longer be the payor source for behavioral health or alcohol or drug-related services as of 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 has worked with me to ensure that any current service providers are aware of this change.

Enrollee's Signature _____

Date _____

Phone Number _____

Parent/Guardian Signature _____

Date _____

Phone Number _____

(Required if enrollee is under 18)

For continuing services, see POC dated: _____

Any additional appointment date(s): _____

RESOURCES:

Resource & Referral Line	257-7607	Owen's Place (Resource Center)	977-4249
Children Mobile Crisis Team	257-7621	Adult Crisis Services	257-7222
Badger Care (T19 enrollment)	800-362-3002	Other:	
IMPACT (Resource & Referral)	211		

REASON FOR DISENROLLMENT:

<input type="checkbox"/> Program Completed	<input type="checkbox"/> Disenrolled to CCS	<input type="checkbox"/> Services no longer desired
<input type="checkbox"/> Disenrolled to Adult Programming	<input type="checkbox"/> Moved out of county	<input type="checkbox"/> Placed in Corrections
<input type="checkbox"/> Medicaid Eligibility Ended	<input type="checkbox"/> Long-term Residential	<input type="checkbox"/> Unable to Contact
<input type="checkbox"/> Missing more than 30 days	<input type="checkbox"/> Other(explain): _____	

For Wraparound and REACH-Ct Order ONLY: Order expired Order revised to remove Wraparound

Care Coordinator Signature _____ Date _____

Supervisor/Lead Signature _____ Date _____

ATTENTION: If you speak English, language assistance services are available to you free of charge. Call your Care Coordinator directly or call 1-833-912-2468 (TTY: 711)

Español (Spanish) - ATENCIÓN: Si habla español, tenemos servicios de asistencia lingüística disponibles de forma gratuita. Llame a su coordinador de atención directamente o bien llame al 1-833-912-2468 (TTY: 711)

Hmoob (Hmong) - CEEB TOOM: Yog koj hais lus Hmoob, muaj cov kev pab txhais lus pub dawb rau koj. Hu xov tooj ncaj nraim rau koj tus Neeg Khiav Hauj Lwm Muab Kev Kho Mob los yog hu rau 1-833-912-2468 (TTY: 711)

မြန်မာ (Myanmar) (Burmese) - အထူးသတိပြုရန် - အကယူ၍
ပြုမြန်မာဘာသာစကားကို သင့်ဝေပြုဟနိုင်းဝိုင်းက ဘာသာစကားဆိုင်
ဝန်ဝေဆာင့်မှုးကို အဆမ့် သင့် ရှိုးဝိုင်းသည်။ သင့် ဝေစာင့်ဝေးကွာကွာ၊
ဆက္စာပါဝေဆာငြာကုပါဝေပေးသူထံသို့၏ တိုကိုကုပါဖုန်းဝေခင့်ဆိုပါ
သို့၏ မဟုတ်လွှာညွေး 1-833-912-2468 (TTY: 711) သို့၏ ဝေခင့်ဆိုပါ