MCDA Family Care Care Management Organization Milwaukee County Department on Aging

LTC: Let's Take Care

REQUEST FOR APPLICATION

Date: _____

Contact Name: _____ Title:_____

Agency: _____

Address: _____

Phone Number: _____Email Address: _____

1. Do you currently have a contract with Milwaukee County Disability Services (DSD)? Yes/no _____
2. Did you receive "Vendor Notice of Case Closure" from DSD indicating a recipient of services from your agency will be enrolling in Milwaukee County Care Management Organization? Yes/No _____
3. What is the projected enrollment date indicated on the "Vendor Notice of Case Closure"? _____

Provider Service Type:

- ☐ Adult Family Home (1-2 bed) Capacity _____
  Ambulatory _____ Semi Ambulatory ____ Non Ambulatory ____
- ☐ Adult Family Home (3-4 bed) Capacity _____
  Ambulatory _____ Semi Ambulatory ____ Non Ambulatory ____
- ☐ Community Based Residential Facility Capacity _____ Class _____
- ☐ Residential Care Apartment Complex Capacity _____ Class _____
- ☐ Skilled Nursing Facility Capacity _____
- ☐ Adult Day Care Capacity _____
- ☐ Transportation
- ☐ Other (Please specify)_____

Client Groups Served:

- ☐ Alcohol/Drug Dependency
- ☐ Developmentally Disabled
- ☐ Emotionally Disturbed /Mentally Ill
- ☐ Correctional Clients
- ☐ Terminally Ill
- ☐ Advanced Aged
- ☐ Physically Disabled
- ☐ Irreversible Dementia/Alzheimer's
- ☐ Traumatic Brain Injury

Please send in this form using one of the following methods:

Mail: MCDA CMO
Attn: Cheryl McQueen
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