



WRAPAROUND MILWAUKEE / REACH / O-YEAH
DISENROLLMENT CONFIRMATION



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 / REACH / O-YEAH 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 / REACH / O-YEAH 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 / REACH / O-YEAH, 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 the Community Resource Guide.

(Participant Signature) (Date) (Parent/Guardian Signature, if under 18) (Date)

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

RESOURCES:

- Families United, Inc. 344-7777 Youth Council977-4249
Mobile Urgent Treatment Team..... 257-7621 Adult Crisis Services..... 257-7222
Badger Care (T19 enrollment)..... 800-362-3002 Project O-YEAH..... 257-7158
IMPACT (Resource & Referral)..... 211 Owen's Place..... 977-4249

Reason for Disenrollment:

- ___ Program completed ___ Program transfer
WRAPAROUND ONLY: ___ to Wraparound
___ Order expired / revised ___ to REACH
___ Moved out of county. ___ to Project O-YEAH
___ Services no longer desired ___ Referred to SAIL / Adult Disability Services
WRAPAROUND ONLY: ___ Placed in corrections
___ Order expired / revised ___ check if correctional placement is in MCAP
___ No contact ___ Referred to BMCW (REACH only)
___ Missing more than 30 days
___ Other (explain): _____

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

Disenrollment Reviewed and Approved by:

Program Staff Date