



2011 Wraparound Milwaukee Provider Network
DIRECT SERVICE PROVIDER ADD REQUEST

Entered by: _____

Date: _____

Date _____ Agency Name _____

Contact Person _____ Phone Number _____ FAX Number _____

CHECK ONE		NOTE: INCOMPLETE forms and forms that are NOT dated and signed will not be processed.					CREDENTIALS					
EMPLOYEE	CONTRACT STAFF	(Check Box if NEW STAFF) PRINT Provider Name (Last Name, First Name)	Provider D.O.B.	CHECK IF BILINGUAL	One Service Per Line REQUIRED Service Code	Service Code and Service Name Must Match Service Name	Required for AODA and Mental Health Providers NPI Number	CHECK ONLY IF ATTACHED				
								15 Hr Training Certificate	Wisc. State License	3000 Hour Letter	University/College Degree	Resume or Letter of Recommendation
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Background checks must have been completed on staff identified above within the last 4 years and must be available for review upon request.

Submit Wisconsin State Dept. of Justice and/or Dept. Regulation and Licensing report to Wraparound for review if a criminal record, denial or revocation is noted.

Agencies on "Conditional Status" are asked to submit 3-part background check for ALL providers of the service/s on "Conditional Status".

Wraparound Milwaukee Use Only:

Prepared by: _____

Date: _____