



SUBMIT FOR PRIOR AUTH REVIEW? _____ Yes _____ No	
If yes, _____ Initial Authorization	_____ Re-Authorization
If yes, _____ Day Treatment	_____ RCCCY
_____ Group Home	_____ Indep Living, Phase 1

**WRAPAROUND MILWAUKEE**

**POC/Child and Family Team Meeting Signature` Sheet**

POC Date: \_\_\_\_\_

Youth Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Care Coordinator Name/Agency Name: \_\_\_\_\_

***REQUIRED TEAM MEMBER SIGNATURES***

		<u>In Attendance?</u>	
		<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	_____	_____	_____
Youth	Phone	E-mail address	
_____	_____	_____	_____
Parent/Legal Guardian	Phone	E-mail address	
_____	_____	_____	_____
Parent/Legal Guardian	Phone	E-mail address	
_____	_____	_____	_____
Care Coordinator	Phone	E-mail address	
_____	_____	_____	_____
Care Coord. Supervisor	Phone	E-mail address	
_____	_____	_____	_____
Consulting Psychologist	Phone	E-mail address	
_____	_____	_____	_____
Consulting Psychiatrist	Phone	E-mail address	

✓ Client Rights  
Reminder

Enrollee/parent/  
legal guardian:

By signing this form you do not give up your right to grieve or appeal what is written in this Plan or the services you are receiving.

***SIGNATURES OF ADDITIONAL TEAM MEMBERS***

_____	_____	_____	_____
Team Member	Relationship To Youth	Phone	E-mail address
_____	_____	_____	_____
Team Member	Relationship To Youth	Phone	E-mail address
_____	_____	_____	_____
Team Member	Relationship To Youth	Phone	E-mail address
_____	_____	_____	_____
Team Member	Relationship To Youth	Phone	E-mail address

POC Date: \_\_\_\_\_

Youth Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Care Coordinator Name/Agency Name: \_\_\_\_\_

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