



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

DIENROLLMENT 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 Disenrollment Summary dated: _____

Any additional appointment date(s): _____

RESOURCES:

Table with 2 columns: Resource & Referral Line, and phone numbers. Includes Owen's Place, Milwaukee County CARS, and IMPACT.

PROPOSED REASON FOR DIENROLLMENT:

- Program Completed, Disenrolled to CCS, Services no longer desired, Disenrolled to Adult Programming, Moved out of county, Placed in Corrections, Medicaid Eligibility Ended, Long-term Residential, Unable to Contact, Missing more than 30 days, Other(explain):

For Wraparound and REACH-Court 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)

မြန်မာစာ (Myanmar) (Burmese) - အထူးသတိပြုရန် - အကယ်၍ မြန်မာဘာသာစကားကို သင်ပြောဆိုနိုင်ပါက ဘာသာစကားဆိုင်ရာ ဝန်ဆောင်မှုများကို အခမဲ့ သင် ရရှိနိုင်ပါသည်။ သင့် စောင့်ရှောက်မှု ဆက်စပ်ဆောင်ရွက်ပေးသူ ထံသို့ တိုက်ရိုက် ဖုန်းခေါ်ဆိုပါ သို့မဟုတ်လျှင်လည်း 1-833-912-2468 (TTY: 711) သို့ ခေါ်ဆိုပါ။

Chinese注意：如果您使用中文，那么您可以免费获得语言协助服务。请直接联系您的护理协调员，或致电 1-833-912-2468 (TTY: 711)。