



MILWAUKEE COUNTY WRAPAROUND MILWAUKEE

Director – Bruce Kamradt

ENROLLMENT REQUEST

MEMBER NUMBER _____

NAME _____
LAST FIRST M.I.

DOB: _____ ENROLLMENT START DATE: _____

HOSPITALIZED AT TIME OF ENROLLMENT _____ YES _____ NO

The enrollment should be faxed to EDS only if the child is not in the hospital

I wish to participate in the Wraparound Milwaukee (WAM) program and voluntarily enroll myself in the program. I also authorize WAM to engage in periodic progress reviews by multidisciplinary review teams.

I understand that by enrolling in WAM I will no longer be enrolled in a Title 19 HMO or any other special managed care program such as PPP (primary provider program) or I-Care (independent care program) for medical services. All physical medical services will be provided by straight Title 19 (also called fee-for-service). All mental health services except medications will be provided only through WAM.

_____	_____	_____	_____
Enrollee's signature (if age 18 or older)	Date	Legal guardian's signature (if enrollee under age 18)	Date

FOR EDS USE:

Enrollment is: APPROVED / DENIED
(circle one)

If denied, reason: _____

Effective start date: _____

County of residence listed for recipient: _____

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