|  |  |
| --- | --- |
| **DEPARTMENT OF HEALTH SERVICES** | **STATE OF WISCONSIN** |
| Division of Care and Treatment Services |  |
| F-00301 (08/2016) |  |
| **2009 WISCONSIN ACT 318 HIGH COST** **MENTAL HEALTH FUND APPLICATION** |
| Completion of this form is voluntary. Failure to complete this form will result in request for funds not being approved. |
| This application is being submitted: (Check only one box below) |
|  | [ ]  | Jointly by the County and Tribe identified below. |
|  | [ ]  | Solely by the Tribe identified below. |
|  | [ ]  | Solely by the County identified below. |
|  | County: |       |
|  | Tribe: |       |
|  |

**Contact Person(s)**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Tribe: | Name: |       |
|  |  | Phone Number: |       |
|  |  | Email Address: |       |
|  |
|  | County:  | Name: |       |
|  |  | Phone Number: |       |
|  |  | Email Address: |       |
|  |

The intent of the High Cost Mental Health Fund is to assist in the financial support for Tribal Court-ordered Mental Health placements. The request for assistance must be based on out-of-home care costs for a member of an Indian tribe or band placed by the Tribal Court.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Mental Health Placement** | **County Cost** | **Tribal Costs** | **Time Period** | **Funding Request** |
|       |       |       |       |       |
|       |       |       |       |       |
|       |       |       |       |       |
|       |       |       |       |       |
|       |       |       |       |       |
|       |       |       |       |       |
|       |       |       |       |       |
|       |       |       |       |       |
|       |       |       |       |       |
| **Total** |       |       |  |  |
|  | - $50,000 | - $50,000 |  |  |
| **Balance** |       |       |  |  |
| **Funding Request** |       |       |  |  |

**SIGNATURES**

|  |  |  |  |
| --- | --- | --- | --- |
|  |       |  |       |
|  | Name – Authorized Tribal Representative |  | Title |
|  |  |  |       |  |
|  | **SIGNATURE** – Authorized Tribal Representative |  | Date Signed |  |
|  |       |  |       |
|  | Name – County Representative |  | Title |
|  |  |  |       |  |
|  | **SIGNATURE** – Authorized County Representative |  | Date Signed |  |
|  |  |  |  |  |
|  | **Approved by DCTS** |  |  |  |
|  |       |  |       |
|  | Name – Authorized Representative |  | Title |
|  |  |  |       |  |
|  | **SIGNATURE –** Authorized Representative |  | Date Signed |  |

Please submit completed form to:

Sarah Coyle, Policy Initiatives Advisor

Division of Care and Treatment Services

PO Box 7851

Madison, WI 53707-7851

Email: Sarah.coyle@Wisconsin.gov

Fax: 608-266-2579