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| **DEPARTMENT OF HEALTH SERVICES**Division of Public HealthF-02906 (09/2023) | **STATE OF WISCONSIN** |
| **AUTHORIZATION TO TRANSFER****AGING AND DISABILITY SERVICES GPR FUNDING TO ANOTHER AGENCY** |
| The purpose of this form is to document authorization to transfer GPR funding awarded to an Aging and Disability Resource Center (ADRC) to another ADRC. Authorization forms must be received by October 31 of the year preceding the contract.This agreement authorizes the Wisconsin Department of Health Services to directly issue **dollar amount** from **Agency 1** to **Agency 2** in calendar year **contract year**.This arrangement is authorized to simplify expense claiming when **Agency 1** and **Agency 2** have a Memorandum of Understanding (MOU) established for **Agency 2** to be the fiscal agent for **Multi select: ADRC Specialist/DCS/DBS** program(s). When submitting this form, please include the applicable MOU documentation from the agencies involved. \*Note: Elder Benefit Specialist (EBS) funds cannot be transferred between ADRCs. Please use [F-02716](https://www.dhs.wisconsin.gov/forms/f02716.docx) to move EBS funding from the county to the ADRC.This agreement is only applicable for the contract term **January 1, 2024 to December 31, 2024**. This transfer of funds cannot be revoked. The agreement will remain in effect for the entire calendar year contract only. If you would like to continue this agreement in future years, you must submit a new form every year.Specify the contact person(s) and their titles from each agency responsible for monitoring and resolving issues in the MOU/agreement. The following ADRCs agree to this arrangement.  |
| **Agency 1** (Entity deobligating awarded funds for use by Agency 2) |
| Authorized Signatory Name: **Click or tap here to enter text.** |
| Title: **Click or tap here to enter text.** |
| Agency Phone Number: **Click or tap here to enter text.** |
| Agency Email Address: **Click or tap here to enter text.** |
| SIGNATURE — Agency 1 | Date Signed |
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| **Agency 2** (Entity receiving deobligated funds from Agency 1 for Agency 2 use) |
| Authorized Signatory Name: **Click or tap here to enter text.** |
| Title: **Click or tap here to enter text.** |
| Agency Phone Number: **Click or tap here to enter text.** |
| Agency Email Address: **Click or tap here to enter text.** |
| SIGNATURE — Agency 2 | Date Signed |
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| **Time and Task Reporting Assurance:**The following ADRC agrees to this arrangement and will ensure that the applicable program staff will complete 100% time and task reporting. Time and task reporting will be submitted via the receiving ADRC’s monthly Adder workbook submission: |
| ADRC Name | ADRC Director Name | ADRC Director Signature | Date Signed |
| **Agency 2** |  |  |  |
| Please submit this form to DHSBADRFiscal@dhs.wisconsin.gov and copy your regional quality specialist on the email submission. |