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| --- | --- | --- | --- | --- | --- |
| **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** |
|  |  |  |  |  |
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|  |  |  |  |  |
| **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](mailto:Sarah.coyle@Wisconsin.gov)

Fax: 608-266-2579