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| **DEPARTMENT OF HEALTH SERVICES** **STATE OF WISCONSIN**  Division of Public Health  F-00053 (03/2022) | | |
| **notice of intent to submit an applicatION** | | |
| Completion of this form is voluntary; however, the information requested would be helpful for the Department of Health Services. | | |
| **1. APPLICANT INFORMATION** | | |
| Name – Aging and Disability Resource Center (ADRC) | | Date of Request |
| Name – Applicant | | |
| **2. CONTACT PERSON** | | |
| Name – Contact Person | Title | |
| Name – Organization | | |
| Address (Street, City, State, Zip) | | |
| Email Address | | Phone Number |
|  | | |
| **3. ADRC SERVICE AREA** | | |
| Counties to be Included: | | Date of Anticipated ADRC Start |
| **4. COUNTY BOARD/TRIBAL GOVERNMENT SUPPORT** | | |
| Is there a county board/tribal government resolution supporting development of the ADRC?  Yes  No | | |