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| **DEPARTMENT OF HEALTH SERVICES** **STATE OF WISCONSIN**Division of Public HealthF-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      |
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| **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 |