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| **DEPARTMENT OF HEALTH SERVICES**  Division of Public Health  F-00575 (08/2019) |  | **STATE OF WISCONSIN** |
| **notice of intent to submit an applicatION FOR  tribal aging and disability resource specialist (Tribal ADRS)** | | |

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| Completion of this form is voluntary; however, the information requested is required as part of the Tribal Aging and Disability Resource Specialist application process. | | |
| Name – Tribe | | Date of Request |
| **CONTACT PERSON** | | |
| Name – Contact Person | Title | |
| Name – Organization | | |
| Address (Street, City, State, Zip) | | |
| Email Address | | Phone Number |
| Counties in Tribal Service Area | | |
| Is there Tribal Council support for the Tribal Aging and Disability Resource Specialist application?  Yes  No | | |