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

|  |
| --- |
| 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 |