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| **DEPARTMENT OF HEALTH SERVICES**  Division of Public Health  F-02140 (02/2024) | | **STATE OF WISCONSIN** | |
| **URGENT SERVICES AGREEMENT** | | |
| Completion of this form is voluntary. However, this form must be completed and accompany your enrollment form if you are requesting urgent services. This form is to be completed by the aging and disability resource center (ADRC) or Tribal aging and disability resource specialist (ADRS).  I have applied to receive services through the managed care benefit and understand that:   * I must meet functional and financial eligibility requirements to receive services. * The Aging and Disability Resource Center or Tribal Aging and Disability Resource Specialist determined I meet the functional eligibility requirements. * My financial eligibility is still pending. * I have met the criteria to request urgent services. * I may be able to begin receiving some “urgent” services while I am waiting for a final decision about my financial eligibility. * If I am determined to not be financially eligible or if I am determined to be financially eligible but decide not to enroll, my services through the managed care organization will end. **I will be responsible for the cost of any services provided to me through the managed care organization. I will cooperate with the managed care organization to setup a payment schedule.**   I would like the Aging and Disability Resource Center or Tribal Aging and Disability Resource Specialist to refer me to the managed care organization right away so I can begin to get the services I need to meet my urgent care needs. | | |
| **SIGNATURE** – Applicant | | Date Signed |
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| Print Name | | |
|  | | |
| **SIGNATURE** – Legal Guardian, Conservator, or Activated Power of Attorney | | Date Signed |
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| **SIGNATURE** – ADRC/Tribal ADRS Authorized Representative | | Date Signed |
|  | |  |
| Print Name | | |
|  | | |
| MCO Selected  Community Care, Inc.  Inclusa, Inc.  iCare  Lakeland Care, Inc.  My Choice Wisconsin. | | |
| This section completed by the MCO | | |
| The request is: | | |
| Approved. Enrollment may occur on or after this date:       . | | |
| Denied. Reason for denial:       . | | |
| **SIGNATURE** – MCO Representative | Date Signed | |
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