### REQUEST FOR STATE PUBLIC FUNDING FOR NON-RESIDENTS

**Use of form:** Use this form to request authorization from the Department for reimbursement of emergency detention expenses for non-Wisconsin residents under Wis. Stat. [§ 51.22 (3)](http://docs.legis.wisconsin.gov/document/statutes/51.22%283%29), and Memo Series 2020-07. Personal information about a client on this form is confidential and is used only for identification purposes. Failure to use this form and to complete ALL INFORMATION applicable to a particular client and attach a copy of the documentation required in Memo Series 2020-07 will result in denial of authorization for reimbursement.

Note: This form is available on the Department’s web site at <https://www.dhs.wisconsin.gov/forms>

|  |  |
| --- | --- |
| **Instructions:** Mail or fax form to:  Emergency Detention Coordinator Division of Care and Treatment Services P.O. Box 7851 Madison, WI 53707-7851 608-266-2715 Fax 608-266-2579 | Date Received in DCTS Central Office      |
| Date Response Sent      |
|  |

|  |  |
| --- | --- |
| Name – County      | Address (Street, City, State, Zip Code)      |
| Name – Contact Person      | Email Address      | Telephone Number      | Fax Number      |
| Name – Facility Serving Client      |
| Address (Street, City, State, Zip Code)      |
| Name – Contact Person      | Telephone Number      |
| Name – Client      | Date of Birth (mm/dd/yyyy)      |
| Address (Street, City, State, Zip Code)      |
| Verification on File of Out-of-State Residency[ ]  Address [ ]  Driver’s License [ ]  Identification[ ]  Others – Specify:       |
| Date – Service Initiation      | Date – Service Completion      | Number of Service Days (Excluding day of discharge)      |
| Other circumstances substantiating the request – Specify.      |
| **DISPOSITION** |
| Check the appropriate disposition. **Attach a copy of applicable court orders, billing statements and police report.** |
| [ ]  | Discharged within 72 hours of initial detention (plus intervening weekends and legal holidays). |
| [ ]  | Probable cause hearing and court order. |
| [ ]  | Settlement agreement and court order. |
| [ ]  | Final commitment hearing and court order. |
| [ ]  | Client – [ ]  initially detained at, or [ ]  transferred to – a state mental health institute. |

|  |
| --- |
| **AUTHORIZATION FOR REIMBURSEMENT OF TRANSPORTATION AND RELATED EXPENSES** |
| Check the box for persons for whom transportation and related expense (T-REX) reimbursement authorization is being requested. Identify the number of persons and the total cost for persons for which T-REX cost reimbursement is being requested. The requirements for determining the amount of reimbursement can be found in DCTS Memo Series 2020-07, regarding “Emergency Detention Services for non-Wisconsin Residents and Procedures for Reimbursement Authorization. |
| [ ]  | Unaccompanied client. Total T-REX cost for client. | $ |       |  |
| [ ]  | Client accompanied by how many qualified staff person(s). |     |  |
|  | Total T-REX cost for client and staff. | $ |       |  |
| [ ]  | Client accompanied by how many relative(s) or friend(s). |     |  |
|  | Total T-REX cost for relative(s) or friend(s). | $ |       |  |
| [ ]  | Client transported by a volunteer driver. | $ |       |  |
| [ ]  | Client transported by law enforcement officials to an allowable setting such as home state residence. | $ |       |  |
|  | Total T-REX cost for client and volunteer driver. | $ |       |  |
|  |  |  |
| **COST AND REIMBURSEMENT INFORMATION** |
| All attempts to obtain reimbursement from other third party payment sources including, but not limited to, the client and / or their family, an insurance carrier or Medical Assistance should be made prior to the county agency requesting reimbursement authorization from the Department. If payments from any third party payment sources are anticipated, please answer the question below explaining any third party payments expected to be applied to the cost of care. If payments from any unanticipated sources are made following submission of the F-20572 form to the Department, notify the Emergency Detention Coordinator of the amounts received as soon as the payments are received. |
|  |
| [ ]  Yes [ ]  No | Does this person have insurance or Medical Assistance coverage applicable to his or her care and treatment? |
|  | If "Yes" to above question, identify the amount (anticipated to be) paid by either of these third party  |
|  | payers, and / or by the individual or his or her family toward the cost of care. | $       |
|  |
| **The total amount for which authorization for reimbursement from the DHS is requested is** | **$**  |

**Note**: Keep approved form in county files for audit purposes.

|  |
| --- |
| **FOR DCTS CENTRAL OFFICE USE ONLY** |
| [ ]  | **Authorization is granted** for the cost of all authorized care and services from the appropriation under  |
|  | Wis. Stat. [§ 20.435 (5) (da)](http://docs.legis.wisconsin.gov/document/statutes/20.435%285%29%28da%29), for: [ ]  Emergency detention services for the client. |
|  |  [ ]  Transportation and related expenses. |
|  |
| **The total amount authorized for reimbursement is** | **$** |  |  **for** |
|  |       | . |
|  | Name – Client |  |
|  |  |
| [ ]  | **Authorization** **is denied** for the following reason(s). |
|  |       |
| **SIGNATURE** – Authorized Person | Date Signed      |