



**WRAPAROUND MILWAUKEE PROVIDER NETWORK  
APPLICATION FOR EXISTING AGENCIES  
TO ADD SERVICES**



**I. GENERAL INFORMATION:** (Please Type or Print)

Agency Name: \_\_\_\_\_

Business Address: \_\_\_\_\_

\_\_\_\_\_

City State Zip

Mailing Address: (if different from Business Address) \_\_\_\_\_

\_\_\_\_\_

City State Zip

Agency Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Agency Director: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Website Address: \_\_\_\_\_

Program Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
(If applicable)

**Program Contact E-Mail Address:** \_\_\_\_\_

**II. NEW SERVICE(S) AGENCY IS REQUESTING TO PROVIDE / EXPERIENCE:**

Each service must have **at least one provider** listed in the "Direct Service Provider" section of the application.

For each service that you are applying to provide, identify below the length of time that your agency has been providing the service, the age range (check all that apply) and type of population served [**youth / adults / AODA / mental health / juvenile justice / developmentally disabled / cognitively limited / sexual-physical abuse**].

<b>Service Name (1)</b>		<b>Service Code</b>	<b>Network Rate</b>
<b>Experience (In Years)</b>	<b>Ages Served</b> <input type="checkbox"/> 0-12 <input type="checkbox"/> 13-18 <input type="checkbox"/> Adult	<b>Populations Served</b>	
<b>Service Name (2)</b>		<b>Service Code</b>	<b>Network Rate</b>
<b>Experience (In Years)</b>	<b>Ages Served</b> <input type="checkbox"/> 0-12 <input type="checkbox"/> 13-18 <input type="checkbox"/> Adult	<b>Populations Served</b>	
<b>Service Name (3)</b>		<b>Service Code</b>	<b>Network Rate</b>
<b>Experience (In Years)</b>	<b>Ages Served</b> <input type="checkbox"/> 0-12 <input type="checkbox"/> 13-18 <input type="checkbox"/> Adult	<b>Populations Served</b>	
<b>Service Name (4)</b>		<b>Service Code</b>	<b>Network Rate</b>
<b>Experience (In Years)</b>	<b>Ages Served</b> <input type="checkbox"/> 0-12 <input type="checkbox"/> 13-18 <input type="checkbox"/> Adult	<b>Populations Served</b>	

Agencies in business for less than five years and with fewer than ten employees are asked to submit two letters of reference (business references only) pertaining to their ability to provide the service(s) for which the individual/agency is applying. Only one of the references may be from an existing agency within the Wraparound Provider Network.

What agencies/organizations have referred business related to the above requested services to you over the past three years?

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**III. DIRECT SERVICE PROVIDER(S):**

**Criminal Background Checks**

Current Criminal Background Checks (within the last 4 years) are required for all employees prior to providing services. **Any criminal background check for any provider showing a prior conviction must be submitted with this application for review by Wraparound Quality Assurance staff.**

Attach a copy of current license and/or certification pertinent to the service to be provided. **Refer to service description list (report available in Synthesis) for detailed credential requirements.**

Please Enter ONE NAME and ONE SERVICE Per Line	Staff Name (Last Name, First Name)	Service Name	Type(s) of Credential Attached					
			State of Wisconsin License	NPI Number	3,000 Hr. Psychotherapy Letter	College / University Degree	15-Hour Training Certificate	Resume or Letter of Recommendation

**THIS SECTION FOR WRAPAROUND USE ONLY:**

**IV. SIGNATURE:**

I agree that all information included in this application is true and correct and that I understand and agree to the application information and requirements. I further acknowledge that the information in this application is subject to periodic verification without notice and that any misrepresentation on this form may result in disqualification from participation in the Wraparound Milwaukee and FISS Programs, and potentially any other County-affiliated programs. Milwaukee County or its designated representative(s) in accordance with applicable law, policies, may take legal action or fiscal sanctions as determined appropriate.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_ **Title:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **E-mail:** \_\_\_\_\_

(Note: Incomplete applications will not be processed.)



**Agency Service Description: (Required if application is approved)**

Following approval to provide the identified service(s), applicants will be asked to provide a detailed description of the new service for inclusion in the Synthesis online resource guide. Descriptions may be submitted on an IBM compatible disc or by e-mail to Theresa Randall at [theresa.randall@milwcnty.com](mailto:theresa.randall@milwcnty.com).

PLEASE RETURN APPLICATION WITH ATTACHMENTS TO:

Wraparound Milwaukee Provider Network  
9201 Watertown Plank Road · Wauwatosa, WI 53226  
PHONE: (414) 257-8108 · FAX: (414) 257-7575  
**ATTN: Theresa Randall**

<i>Office Use Only:</i>	
<input type="checkbox"/> APPROVED	<input type="checkbox"/> DENIED    Start Date: _____
<b>Additional Comments:</b> _____	
_____	
_____	
<b>Approved By:</b> _____ <b>Date:</b> _____	