 <b>WRAPAROUND MILWAUKEE Policy &amp; Procedure</b>	Date Issued: <b>9/1/98</b>	Reviewed: <b>12/6/10</b> By: <b>CP</b> Last Revision: <b>12/7/10</b>	Section: <b>ADMINISTRATION</b>	Policy No: <b>016</b>	Pages: <b>1 of 2</b> (3 Attachments)
	<input checked="" type="checkbox"/> Wraparound <input checked="" type="checkbox"/> Wraparound-REACH <input type="checkbox"/> FISS <input type="checkbox"/> Project O-Yeah	Effective Date: <b>1/1/11</b>	Subject: <b>DISENROLLMENTS</b>		

## I. POLICY

The purpose of this policy is to provide guidelines and assistance to the Care Coordinator and family with the potential reasons for Disenrollment, as well as Disenrollment procedures and expectations.

## II. PROCEDURE

### A. Possible Reasons for Request for Disenrollment.

1. Youth/family has made substantial progress [towards meeting their needs and vision.](#)
2. Youth/family moved out of county.
3. Youth/family no longer desire Wraparound services.
4. Youth missing more than 30 days. *(These youth should be scheduled for disenrollment, if they will be missing more than 15 days by the beginning of the month.)*
5. Placed in corrections.
6. Other *(explain)*.

**For All Wraparound Enrollments** – unless the youth is being disenrolled on runaway status or placed in corrections, the court order must either have expired or been vacated.

### B. Guidelines for Disenrollment.

1. Disenrollment should be planned for during the entire Wraparound process. Youth meeting any of the above criteria should be scheduled for Disenrollment. A Disenrollment Plan of Care (POC) Meeting must occur with the entire Child & Family Team the month prior to disenrollment. The Care Coordinator's Supervisor or Lead Worker must be present for the Disenrollment Plan of Care Meeting and must sign off on all documents including the POC Attendance Sheet. At this meeting, the Team must ensure that the family is informed of all ongoing services and follow-up care needed, and is made aware of how to obtain these services. For families covered under Medicaid insurance, the Care Coordinator must explain the insurance changes that will occur and ensure that the family is aware of the impact these changes may have on services available.
2. The Care Coordinator is responsible for notifying all Team members of the Disenrollment. This includes both paid providers – and informal supports.
3. To request that a Disenrollment be processed, the Care Coordinator must discuss the youth/family progress with their Supervisor or Lead Worker and request that the Supervisor or Lead Worker attend the Disenrollment Plan of Care Meeting. The Agency Supervisor or Lead Worker then enters the Disenrollment Date on the Referrals tab in Synthesis. **To ensure timely notification to Medicaid of the upcoming disenrollment date, this date needs to be entered prior to the 10<sup>th</sup> of the disenrollment month.**
4. During the final visit with the youth/family, the Care Coordinator has them complete the DISENROLLMENT CONFIRMATION FORM *(see Attachment 1)* and DISENROLLMENT PROGRESS REPORT *(see Attachment 2)*. Any ongoing services or follow up needed must be again reviewed with the family and written on the Disenrollment Confirmation Form. A copy of the Disenrollment Confirmation Form is left with the family.

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5. After the final visit with the family, the Care Coordinator submits all Disenrollment paperwork to Wraparound Milwaukee:
  - Disenrollment Confirmation Form (signed by parent, youth, Care Coordinator and Supervisor)
  - Disenrollment Progress Report
  - Evaluation Tools

Payment for the final month of care coordination will be released after submission of the signed Disenrollment Confirmation Form.

6. The family may choose to appeal the decision by submitting a Wraparound Milwaukee APPEAL FORM (*see Attachment 3*).

Reviewed & Approved by: Bruce Kamradt  
Bruce Kamradt, Director




# Wraparound/REACH Disenrollment Progress Report

Youth's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Care Coordinator: \_\_\_\_\_ Agency: \_\_\_\_\_


**You are now getting ready to leave the Wraparound or the REACH program. We would like to know what kind of progress you feel you and your child have made.**

 <b>Parent / Guardian Questions</b>	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Doesn't Apply
1. I feel my family has made significant progress in meeting the Family Vision we have been working towards.	1	2	3	4	5	N/A
2. I feel my child's educational needs have been met.	1	2	3	4	5	n/a
3. Overall, I feel that Wraparound/REACH helped me be more able to handle challenging situations.	1	2	3	4	5	n/a
4. I feel that I have family, friends and community resources that will be there for me and my family if we need them.	1	2	3	4	5	n/a
5. If my family does have a crisis, I believe the final Crisis Plan my Team developed will help us.	1	2	3	4	5	n/a
6. After disenrollment I will know how to get services and supports that my family may still need.	1	2	3	4	5	n/a

On a scale of 1-5 (1 being very poor, 5 being very good):

How do you feel your family was doing when first enrolled? (circle one)      1      2      3      4      5

How do you feel your family is doing now?      1      2      3      4      5

 <b>Youth Questions</b>	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Doesn't Apply
1. I feel that I'm doing better in school than I was before	1	2	3	4	5	n/a
2. I feel like I'm getting along better with my family than I did before.	1	2	3	4	5	n/a
3. I feel like I'm getting along better with my friends than I did before.	1	2	3	4	5	n/a
4. I feel my behavior is better since I was enrolled.	1	2	3	4	5	n/a

On a scale of 1-5 (1 being very poor, 5 being very good):

How do you feel you were doing when you first enrolled? (circle one)      1      2      3      4      5

How do you feel you are doing now?      1      2      3      4      5

Caregiver Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Youth Signature: \_\_\_\_\_ Date: \_\_\_\_\_


# Wraparound/REACH

## Reporte de Progreso Desinincipcion

Nombre del Joven: \_\_\_\_\_ Fecha de Nacimiento \_\_\_\_\_

Coordinador del cuidado \_\_\_\_\_ Agencia: \_\_\_\_\_


**Ahora usted se esta preparando para dejar el programa Wraparound o el REACH. Queremos saber que clase de progreso usted siente que usted y su hijo(a) han hecho.**

 Preguntas del Padre / Guardian	Totalmente de acuerdo	De acuerdo	Neutral	En desacuerdo	Totalmente en desacuerdo	No aplica a mi persona
1. Siento que mi familia ha hecho un progreso significativo al cumplir la Vision Familiar por la cual hemos estado trabajando.	1	2	3	4	5	N/A
2. Las necesidades educacionales de mi hijo han sido cumplidas.	1	2	3	4	5	n/a
3. En conjunto, siento que Wraparound ayudo a facultar a mi familia para manejar situaciones dificiles.	1	2	3	4	5	n/a
4. Siento que tengo familia, amigos y recursos de la comunidad que estaran disponibles para mi y mi familia si lo llegaremos a necesitar.	1	2	3	4	5	n/a
5. Si mi familia tiene una crisis, creo que el plan final de crisis que el Equipo diseno nos ayudara.	1	2	3	4	5	n/a
6. Despues de darle de baja del programa, yo sabre como buscar servicios y ayuda que mi familia pueda necesitar.	1	2	3	4	5	n/a

En una escala del 1-5 (1 siendo muy mal, 5 siendo muy bien):

¿Como usted siente que su familia estaba cuando primero se matricularon? (circule uno) 1    2    3    4    5

¿Como usted cree que su familia eseta ahora? (circule uno) 1    2    3    4    5

 Preguntas al Joven	Totalmente de acuerdo	De acuerdo	Neutral	En desacuerdo	Totalmente en desacuerdo	No aplica a mi persona
1. Siento que estoy haciendo mejor en la escuela ahora que antes.	1	2	3	4	5	n/a
2. Siento que me estoy llevando mejor con mi familia ahora que antes.	1	2	3	4	5	n/a
3. Siento que me estoy llevando mejor con mis amigos ahora que antes.	1	2	3	4	5	n/a
4. Siento que mi comportamiento ha mejorado desde que me matricule en el programa.	1	2	3	4	5	n/a

En una escala del 1-5 (1 siendo muy mal, 5 siendo muy bien):  
¿Como usted se sentia cuando primero se matriculo? (circule uno) 1    2    3    4    5

¿Como se siente ahora?(circule uno) 1    2    3    4    5

Firma del Encargado:: \_\_\_\_\_ Date: \_\_\_\_\_

Firma del Joven:: \_\_\_\_\_ Date: \_\_\_\_\_

## APPEAL FORM

DATE: \_\_\_\_\_

TO: **Wraparound Milwaukee Clinical Coordinator**

FROM: (Name) \_\_\_\_\_

(Address) \_\_\_\_\_

(Phone) \_\_\_\_\_

.....

**Type of Appeal:**     \_\_\_\_\_ Referral / Enrollment  
                              \_\_\_\_\_ Disenrollment

**Youth's Name** \_\_\_\_\_

**Reason for Appeal** \_\_\_\_\_

**Desired Outcome** \_\_\_\_\_

**Other Comments** \_\_\_\_\_

**Date(s) available for Hearing** (if requested) \_\_\_\_\_

**Return To**  
**Enrollment Coordinator**  
Wraparound Milwaukee  
9201 Watertown Plank Road  
Milwaukee, WI 53226