

Tuberculosis Treatment Assistance Program Enrollment and Agreement

Instructions

Please return completed form to the Wisconsin Department of Health Service's TB Treatment Assistance Program: 201 E. Washington Ave., Room G100 Madison, WI 53703 or dhswitbprogram@dhs.wisconsin.gov.
Phone: 608-261-6319, Fax: 608-266-0049

Agency information

Agency name: _____

Agency address: _____

Agency contact person: _____

Phone number: _____ Email: _____

Agreement

- I, as the agency contact person listed above, have read the TB Treatment Assistance Program *Policies and Procedures Manual*. I agree to follow the policies and procedures outlined in this document.
- I, as the agency contact person listed above, understand that only those that have read the TB Treatment Assistance Program *Policies and Procedures Manual* and have signed this form may submit reimbursement requests to the TB Treatment Assistance Program.
- As a participant in the Wisconsin TB Treatment Assistance Program, I, as the agency contact person listed above, agree to spend funds made available through the program only to provide treatment assistance aids to clients with TB or latent tuberculosis infection (LTBI).
- As a participant in the Wisconsin Tuberculosis Treatment Assistance Program, I, as the agency contact listed above, agree to purchase only treatment assistance aids allowable through the program (see Table 1 of the *Policies and Procedures Manual*) and will request pre-approval for any aids above the indicated capped amounts (\$50 for LTBI, \$200 for active TB disease).
- For reimbursement, I, as the agency contact listed above, agree to submit the completed and signed *Request for Reimbursement Form* and purchase receipts to the Wisconsin TB Program. I understand that purchases must be verified before reimbursement.

Signature — Agency contact: _____

Date signed: _____

Signature — Health officer (or designee): _____

Date signed: _____

Signature — DHS/DPH TB Program staff: _____

Date signed: _____