TUBERCULOSIS (TB) TREATMENT ASSISTANCE PROGRAM ENROLLMENT AND AGREEMENT

Agency Name

Agency Address

Agency Contact Person

Phone	**Email**

- 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

Please return to:

Wisconsin Department of Health Services
TB Treatment Assistance Program
1 W. Wilson Street, Room 255
Madison, WI 53703
Phone: 608-261-6319
Fax: 608-266-0049
Email: DHSWITBProgram@dhs.wisconsin.gov