

WINONA COUNTY REENTRY ASSISTANCE PROGRAM+ CONFIRMATION OF PARTICIPANT STATUS (Revised 8/22/23)

To be completed by the case manager. Internal Use Only.

Client Name:	DOB:
Client Name: First Name/Last Nam	ne
WRAP+ Release of Information AND murecommends ARMHS (unless the Acceptavailable to Accepted Applicants to pay f	ant to become a Participant, the Accepted Applicant must sign a list have a valid comprehensive mental health evaluation that ed Applicant is a Treatment Court Participant). Funding is for a comprehensive mental health evaluation if there are no t. To access funding, the Case Manager should complete a
The above client has signed a WRAP+ Re	lease of Information. Date signed:
The above client has a valid comprehensive	ve mental health evaluation. Details are provided below:
	Type of Assessment:
• Diagnosis:	
• Treatment Recommendations:	
ARMHS is one of the treatment in treatment court).	nt recommendations (must be checked, unless Accepted Applicant is
	not required for an Accepted Applicant to become a Participant, trant reporting purposes. Please provide the following information ment completed by the above individual.
Date of Assessment:	Type of Assessment:
• Assessing Agency/Individual:	
• Treatment Recommendations:	
Case Manager Name:	Date Completed/Updated:
Printed Name:	Title:

Please e-mail this form to Kalene Engel at kalene@engellawoffice.com when complete so that the change in status can be recorded and the Accepted Applicant's file can be transferred to the Participant folder. Kalene will transfer the folder from the Accepted Applicant to the Participant folder.