Department of Workforce Development
Unemployment Insurance Division
P.O. Box 7905
Madison, WI 53707

Fax: (608) 260-2506
Email: UIDrugTest@dwd.wi.gov

Substance Abuse Treatment Enrollment

Please return completed form by mail, fax or encrypted email within 5 days of the date of enrollment. Failure to return the form could result in denial of benefits to the claimant and no payment for services will be processed.

Individual Information

First Name	Middle Initial	Last Name		
Address	City		State	Zip Code
Social Security Number	ID Number			

Treatment Facility Information

Treatment Facility Name			
Address	City	State	Zip Code
Contact Name	Title	Phone Number	

Treatment Facility Certification

☐ I certify that the individual enrolled in a substance abuse treatment program:

Date of enrollment: _____/_____/_____.
Individual is deemed enrolled when an assessment is scheduled for the earliest date available.

☐ I certify that the individual has contacted our facility for enrollment in a substance abuse treatment program within the required time frame, but the facility currently does not have an opening to enroll the individual for the recommended treatment.

Name of Treatment Facility Employee Completing This Form	Title
Phone Number	Date / /