Kids deserve the best.

## Children's Wisconsin Behavioral Health Services: Out of Home Care

The following is a checklist of paperwork which is to be submitted to the Access Center prior to a client being placed on the waitlist for services. Forms are to be completed fully and signed by a legal guardian, as noted on the form. Incomplete forms will result in a delay in scheduling service(s) requested.

Please return the below documents to the Mental and Behavioral Health Access Center.

______ Service Referral Form

______ Therapy Family History Form

______ Consent for Mental Health Care

______ Consent for Treatment

______ Any collateral paperwork as appropriate (Previous psychological evaluation, IEP, etc)

Please provide the below information sheets to the legal guardian.

______ Information for Clients

______ Rights and Responsibilities/Grievance Procedure

All documents may be emailed to MBHAccessCenter@chw.org. The Access Center can be reached at 414-266-3339 with any questions.

We look forward to working with you.

Kids deserve the best.

## Out of Home Care – Service Referral Form

**Referring Provider Information:**

Referral Person: ______________________________ Relationship to Client: ____________________

Agency: CHWCS: _____ SaintA: _____ TFC: ____________________ Other: ____________________

Phone Number: ______________________________ Email: _________________________________

Foster Parents: _________________________________ and _________________________________

Phone number(s): ______________________________________________________________________

Address: ___________________________________________________________________________

City: _________________________________ State: _________ Zip Code: __________________

Date of TPC: ___________________ Number of placements the child has resided in: ________________

Child's Name: _________________________ Date of Birth: __________________ Gender: _________

Legal Guardian(s): _____________________________________________________________________

What is the primary problem for which you are seeking help? Specify symptoms, problem behaviors, emotional concerns, etc):_______________________________________________________________

_____________________________________________________________________________________

**Service(s) Requested:** (Circle all requested services)

Therapy Psychiatry/Medication Evaluation Psychological Evaluation

Bonding Assessment Preschool Mental Health Assessment (3-5yo)

Infant Mental Health Assessment (0-2yo)

Location Preference: ____________________________________________________________________

Were any of the services court ordered? Yes: ___ No: ___ If yes, which services: ______________

Specific Provider Requested? Yes: ___ No: ___ If yes, name: ____________________________________

**Previous/Current Services:**

Has the child received treatment prior to this referral? Yes: ___ No: ___

If yes, Please complete the following, indicating when and where services were/are received:

Therapy: ____________________________________________________________________________

Psychiatry/Medication Management: _______________________________________________________

Psychological/Neuropsychological Evaluation (please include the evaluation with the packet):

_____________________________________________________________________________________

**Please email all referrals to MBHAccessCenter@chw.org**

## Therapy Family History Form

### I. Child's Information

Child's Name: ____________________ Child's Preferred Name: ____________

Date of Birth: ____/____/______ Gender: __________

Names of parent/guardian: ____________________

Name of person completing this form: ____________________ Relationship: __________

Best Contact Number(s): ____________________

Child's Race Ethnicity: ____________________

Language(s) spoken at home: ____________________

What would be helpful for us to know about your family's religious/spiritual life? ____________________

____________________

Parent's marital status:

Parent: ☐ Married ☐ Domestic Partner ☐ Single ☐ Divorced ☐ Separated ☐ Widow

Parent: ☐ Married ☐ Domestic Partner ☐ Single ☐ Divorced ☐ Separated ☐ Widow

Is the child in foster care? ☐ No ☐ Yes, please list Child Welfare case worker's name and contact number

Name: ____________________ Contact Number: __________

If the child is placed out of the home, how many placements has the child been in: __________

Is the child adopted? ☐ No ☐ Yes, If yes at what age was the child adopted? __________

Does the child know that he/she is adopted? ☐ No ☐ Yes

Others currently living in the home:

| Name | Sex (check one) | Age | Relationship |
|---|---|---|---|
| | ☐ M ☐ F | | |
| | ☐ M ☐ F | | |
| | ☐ M ☐ F | | |
| | ☐ M ☐ F | | |
| | ☐ M ☐ F | | |

Tell us about your child's strengths and interests:

____________________

____________________

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## II. Developmental History

Was the child born premature (early)? ☐ No ☐ Yes, how many weeks early? ____________

Were there any problems/illnesses during pregnancy or delivery? ☐ No ☐ Yes, explain ____________

____________________________________________

Any use of tobacco, alcohol, or recreational drugs during pregnancy? ☐ No ☐ Yes, list: ____________

____________________________________________

Any use of prescription medications during pregnancy? ☐ No ☐ Yes, list: ____________

____________________________________________

Write the age at which the child first started to:

_____ Speak words _____ Crawl _____ Toilet-train during day

_____ Speak sentences _____ Walk _____ Toilet-train during night

Has the child had any of the following:

☐ No ☐ Yes Physical Therapy

☐ No ☐ Yes Occupational Therapy

☐ No ☐ Yes Speech Therapy

☐ No ☐ Yes Drug or Alcohol Treatment

☐ No ☐ Yes Child Protective Services

☐ No ☐ Yes Other Community Resources (i.e. FISS, birth to 3, autism therapy, etc.)

If you answered yes to any of the questions above please explain:

____________________________________________

____________________________________________

## III. Mental Health History

Has your child been seen for any Mental Health Concerns before? ☐ No ☐ Yes, If yes, list dates and providers (e.g. therapist/psychologist/psychiatrist, psychological testing, hospitalization, etc.) ____________

____________________________________________

____________________________________________

## IV. Other Medical History

**CHILD MEDICAL HISTORY**

Please check only those that apply

| | Yes | Explain |
|---|---|---|
| Any allergies to: food, medications, environment? | | |
| Any blood disorders? | | |
| Problems with eating? | | |
| History of head injury or memory concerns | | |
| Headaches or loss of consciousness | | |
| Concussion | | |
| Any heart conditions/problems? | | |
| Diabetes? | | |
| Seizures? | | |
| Liver disease? | | |
| Stomach problems? | | |
| Problems with bed wetting or urination | | |
| Bowel movements or menstruation? | | |
| Other chronic medical issues? | | |

## IV. Other Medical History

Approximate hours of sleep per night?: ____________________

Any problems with nightmares?: ____________________

Other concerns related to sleep: ____________________

List all other providers, doctors, or specialists the child sees now:

| Name | Reason | Date last seen |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Attach additional documentation as needed.

List all medications the child takes now **(please bring pill bottles to the first visit):**

| Medication Name | Dose | Times | Reason |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

## V. Psychiatric Symptoms and History

Which of the following symptoms has the child shown? Please check only those that apply.

| | Yes | Comments |
|---|---|---|
| **Mood/Emotional Concerns** | | |
| Sad often | | |
| Cries easily/often | | |
| Suicidal thinking or attempts | | |
| Irritable/grouchy | | |
| Anxious | | |
| Frequent changes in mood | | |
| Withdrawn | | |
| **Behavioral Concerns** | | |
| Self-harm or cutting | | |
| Aggressive/violent | | |
| Temper tantrums | | |
| Sexual or risky behaviors | | |
| Hyperactive | | |
| Impulsive (acts without thinking) | | |
| Poor attention span | | |
| Stealing | | |
| Leaving home or school | | |
| Destructive to property | | |
| **Substance Use** | | |
| Known or suspected alcohol or drug use | | |
| **Other** | | |
| Tics (uncontrolled movement or vocal tic) | | |
| Mute (won't talk) | | |
| Blank staring | | |
| Difficulty with friendships | | |
| Obsessive (unwelcome) thoughts | | |

| | Yes | Comments |
|---|---|---|
| **Other (continued)** | | |
| Compulsive (repeated) behaviors | | |
| Seeing things that aren't there | | |
| Hearing voices | | |
| Paranoid thinking | | |
| **Trauma/Loss** | | |
| Witness to violence, verbal or physical abuse | | |
| Loss/death / Separation | | |
| Abused physically, mentally or sexually | | |

## VI. Family Educational History

**If child has a current IEP in school bring to first appointment**

Parent: Highest level of education: ____________ Parent: Highest level of education: ____________

## VII. Other Family Information

Parent: Current Employer and Job Title: ____________

Parent: Current Employer and Job Title: ____________

Household income: ____________ Are there any active or former military members in the household? ________

______________________________________________

## VIII. Social History

Please describe the child's social activities: ____________

How many close friends would you say the child has? ____________

How much time each day does the child spend with friends? ____________

## X. Family Health History

Please check the boxes for **family members** who have had any of these illnesses:

| | Patient | Mother | Father | Brothers/Sisters | Other (list) |
|---|---|---|---|---|---|
| ADHD/ADD | | | | | |
| Anxiety | | | | | |
| Bipolar/mood swings | | | | | |
| Depression | | | | | |
| Schizophrenia | | | | | |
| Post-traumatic stress disorder | | | | | |
| Personality disorder | | | | | |
| Suicidal thinking or attempts | | | | | |
| Other mental health (describe) | | | | | |
| Alcohol or drug abuse | | | | | |
| Head injury | | | | | |
| Learning problems or disabilities | | | | | |
| Thyroid problems | | | | | |
| Other health concern | | | | | |

Questions or other information (if none, leave this section blank and sign/date bottom of this page):

______________________________________________

______________________________________________

______________________________________________

Parent/Guardian Signature: ____________________ Date: ________

Children's
Hospital of Wisconsin

Ambulatory and
Community Services

# Consent for Mental Health Care

- **Please read this form.**
- **Ask questions about anything you do not understand before you sign this form.**
- **When you sign it, you are giving us permission to treat you or your child.**

**I understand and agree that** taking part in mental health care at Children's Hospital of Wisconsin (CHW) is my choice.

**To help me understand the care,** I will get information about the following:

- The type of mental health care I/my child will get in this clinic
- Recommendations and benefits of care, as well as possible results and side effects
- How long care may last and desired outcomes recommended in my treatment plan
- My rights and responsibilities in this clinic. This includes my participation in care and the development and on-going review of my treatment plan
- Other choices for care
- How to report a problem. This is called a grievance procedure

**I have been offered a "Clients Rights and the Grievance Procedure for Community Services" brochure.**

**Fees** are based on the length and type of care. I am responsible for any amount not paid by insurance. Co-payments and deductibles are not paid by insurance. I may ask for a list of fees at any time.

Information from each visit is kept in your/your child's CHW medical record. My/my child's mental health records may be shared with health providers, insurance companies and Children's Hospital and Health System for treatment, payment and health care operations.

**I understand that care will be finished in the clinic and I will be discharged if:**

- Treatment is finished or I ask to stop care.
- I miss visits, do not call the provider, or fail to return a call after missing a lot of care.
- I am referred to another agency for different care.
- I do not follow the recommended care or cause problems in the clinic that are disruptive.

I have the **right to remove my consent** for mental health care at any time. I need to make this request in writing. This consent lasts for 15 months from the date of signature.

**I have read this information. I am legally able to consent for my child.**

**Signature: X**____________________ **Date:** ________ **Relationship to patient:** __________

**Signature of patient/client age 14 years and older: X**____________________ **Date:** ________

**Signature of witness: X**____________________ **Date:** ________ **Time (Required):** ________

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PATIENT LABEL HERE

# Consent for Treatment

**Please read this form. Ask questions about anything you do not understand before you sign.**

**Treatment**

- I authorize doctors, other providers and Children's Hospital of Wisconsin (CHW) employees to evaluate and treat my child. This may include, but is not limited to, all routine hospital services, physical examinations, x-rays, labs, administering or prescribing medications including immunizations and ordering or performing other tests or procedures. I have the right to discuss options for my child's treatment. I will be given a chance to ask questions as needed.
- A hospitalist or a specialty doctor may be assigned to treat my child. CHW staff will carry out the instructions of these doctors. I understand that most doctors who care for my child are not employees of CHW. CHW is not responsible for their actions.
- My child may go home or to another facility before all medical problems are known or treated. I agree to make appointments for follow-up care.
- CHW is a teaching hospital and supports the training and teaching of health care professionals. Students may be involved in providing my child's care.
- CHW may use or properly dispose of any samples or tissues taken from my child's body.

**Patient Rights and Privacy**

- Patient/Family Rights and Responsibilities information is posted throughout CHW. I may request a copy. It is also available at CHW.org.
- I received the Notice of Privacy Practices. It explains how my child's health information may be handled and is posted throughout CHW and is available at CHW.org.
- Photographs and recordings may be taken by CHW for care, training, education or security purposes. I am not allowed to take photos or videos of other patients or of staff when they are providing care to my child.
- My child's medical records may be shared with health providers, insurance companies and Children's Hospital and Health System for treatment, payment and health care operations.
- CHW is not responsible for my valuables. I understand that I should take anything valuable home.

**Financial Agreement**

- I will receive more than one bill for my child's inpatient or outpatient appointment. All insurance payments for my child's care are paid to CHW and to providers who may care for my child. I understand that I am responsible for charges not covered by insurance.

**Communication**

- You may need to call, email or text me about appointments, treatment, billing and collections. Prerecorded messages and auto-dialers may be used when contacting me. I give you permission to contact me at any of the telephone numbers/email addresses provided and know that may result in charges to me.

**I have read this information. I am legally able to consent for my child. By signing this form, I give my permission for treatment and agree to the terms listed above. My consent for clinic visits is good for one year.**

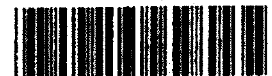
**Signature: X**____________________________ **Relationship to Patient:** ________________
Patient, Parent or Legal Guardian

**Date:** __________ **Time:** __________ **Verbal Consent:** ☐ **Yes** ________________
Relationship to Patient

____________________________
CHHS Witness to the Signature

____________________________
Second CHHS Witness to Verbal Consent

☐ Parent/Legal Guardian ID verified (Inpatient/Day Surgery only) by: ________________ **Date:** ________ **Time:** ________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Kids deserve the best.

Child and Family Counseling

# INFORMATION FOR CLIENTS



Welcome to Children's Wisconsin. **You are in good care here.** Our goal is to strengthen families and promote child and adolescent well-being through holistic, recovery-focused care.

**This sheet contains important information about your/your child's care with us.** Please read it carefully. Talk to your provider or anyone on our team about any questions you may have. A provider is a therapist, psychiatrist, or psychologist who is helping you/your child with your/your child's mental health care. Our team also has leaders and front office staff members who are ready to help you meet your needs.

## Who We Serve

We care for children and adolescents ages 0-18 and their families in outpatient locations such as clinics or certain schools. If there is any reason why we are not the best place to care for you, we will explain why and help you find care elsewhere.

## Hours

Clinic hours are Monday through Friday 8:00 a.m. to 6:00 p.m. by appointment. Evening and weekend hours may be available. Ask your provider for more information.

## Telehealth

We offer both face-to-face visits in our clinics and telehealth from your home, through a **MyChart** app. Talk to your provider about these options.

If you wish to set up your **MyChart** account for telehealth access, reminders, bill pay, and other benefits to your care, download the MyChart app and follow the prompts to register, or visit https://mychart.chw.org/MyChart/Authentication/Login

## Attendance and Cancellations

**It is important to come to all of your scheduled visits. Not attending appointments delays your care. If you are not able to make an appointment, call (414) 266-3339 as soon as you can.**

A **no-show** is when you:

- do not show for a scheduled appointment

A **late cancel** is when you:

- Cancel a visit **less** than 24 hours before your appointment (including after the scheduled appointment time)
- Arrive when more than ½ of your appointment time has passed.

If you have **3** no-shows and/or late cancels within a 1 year time from your first visit with your provider, you may not be able to schedule more visits in our clinic.

COVID-19: If you or your child has any COVID-19 symptoms (fever, cough, or shortness of breath) and you are receiving our services in the clinic, please call the clinic immediately. We will work with you to arrange for telehealth visits until your family is well and able to return to clinic.

## Emergencies

**In the event of a life-threatening emergency, call 911.**
If you have a non-life threatening emergency that happens during clinic hours, you may call the office at (414) 266-3339 to speak to your provider. If your provider is not available, you may be connected with another provider, supervisor, or manager. If you call outside of clinic hours, you will be connected to an answering service to assist you.

## Suicide Prevention

You matter! Here are some helpful, hopeful resources for you. Talk to your provider if you have questions or concerns, or would like more local resources.

**The National Suicide Prevention Hotline: call 1-800-273-8255 (1-800-273-TALK).**
The Lifeline provides 24/7 free and confidential support for people in distress, prevention and crisis resources for you or your loved ones.

**211 Impact – Help Starts Here**
Provides 24-hour mental health crisis intervention, information, referral and listening support. Simply dial 2-1-1 from any phone, text your ZIP code to 898211, or visit www.impactinc.org.

**Crisis Text Line**
Text 741741 from anywhere in the US to text with a trained Crisis Counselor. Crisis Text Line is free, 24/7 support for those in crisis.

## Safety

We want our guests to feel safe in all of our locations. If you or anyone with you creates an unsafe environment, we will cancel your visit if we can't keep you, our staff, and our other guests safe. All Children's buildings are firearm/weapon-free spaces.

## Treatment Record Requests

You may request copies of your medical records by calling **(414) 266-2301** or fax (414) 266-6316. **The clinic staff, including your provider, is not allowed to give you medical records from the office.**

## Email and Social Media

For your safety and privacy, **your provider is not allowed to respond to your or your child's calls to their personal phones, emails, or texts. They also may not accept any social medial requests.** If you need to talk to your provider about your care, call the clinic to talk to them or schedule an appointment to see them.

## Cost of Care

At Children's Wisconsin, we provide the best and safest care regardless of a family's ability to pay. If you think you may need assistance, our Financial Assistance Policy and Application form are available:

- https://childrenswi.org/patients-and-families/billing-payment/financial-assistance
- By phone at (414) 266-6262 or toll-free (888)449-4998

Families are responsible to pay any out of pocket expenses not covered by insurance or financial assistance. For estimated prices for our care, please make a request through https://childrenswi.org/patients-and-families/billing-payment/price-request

## Your 100% Satisfaction is Our Goal

We want you to be completely satisfied with the mental health services we provide to you. You may receive a survey in your email and/or text after your appointment with us. Please take time to share your opinions and feedback so we can always work to improve our work. You will receive no more than 4 of these surveys per year. You may also provide feedback directly to your provider or the clinic manager.

Kids deserve the best.



If you believe that your rights have been violated, please call 414-266-7848 or toll free (800)556-8090 and ask to speak with a Client's Right's Specialist (there will be no consequences for or retaliation against you or anyone assisting you in the filing of a complaint or grievance). Make sure to accept or ask for a copy of our *Clients Rights and the Grievance Procedure* Brochure from the front office or your provider at any time.

**Manatee – An app that helps**

Children's Wisconsin is proud to partner with Manatee, an application for your phone, tablet, or computer that our providers can use to help you stay connected throughout you or your child's therapy. Manatee sets and tracks goals that support you/your child's progress, provides ideas and helps make therapy engaging and motivating. Whether this is guided by a therapist or by your family, Manatee extends the impact of therapy beyond office visits. Get started by visiting GetManatee.com/parents or ask your provider for more information.

Thank you for choosing Children's Wisconsin for your/your child's mental health care.

Sincerely,

Tracy Oerter
Director, Community-Based Mental and Behavioral Health
Children's Wisconsin
TOerter@chw.org

# Rights and Responsibilities /Grievance Procedure

Community Services and Mental Health

chw.org/communityservices

Kids deserve the best.


**Your Client's Rights Specialist**

Children's Hospital of Wisconsin
Patient Relations
PO Box 1997, MS 939
Milwaukee, WI 53201
(414) 266-7848 or (800) 556-8090
TTY (414) 266-2465
Fax (414) 266-6669
PatientRelations@chw.org


Rights information taken from Wisconsin Statute sec. 51.30 and 51.61(1) and HFS 92 and 94 of the Wisconsin Administrative code.

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## You or your child have the right to:

- Fair, timely and appropriate care.
- Care that respects you or your child's age, cultural, emotional, developmental and social needs.
- Care in a setting free from prejudice, harassment, neglect or abuse.
- Be treated in the least restrictive manner and setting necessary.
- Participate in care, care planning and consent.
- For children receiving mental health services:
  - If you are less than 14 years old a parent or guardian must agree in writing to you receiving treatment.
  - If you are 14 years or older:
    - You and your parent or guardian must agree to you receiving outpatient treatment.
    - If you want treatment and your parent or guardian does not agree to it you can petition the county Mental Health Review Officer (MHRO) for a review.
    - If you do not want treatment but your parent or guardian does, the treatment director for the clinic where you are receiving your treatment must petition the MHRO for a review.
      - If you want more information about the MHRO, please let a staff member know.
- Participate in medication management as needed.
- Information about treatment and care, including alternatives and possible side effects of treatment.
- Give written, informed consent to all treatment or medications unless needed in an emergency to prevent serious physical harm to you or others, or if a court orders it.
- Only be filmed, taped or photographed if you agree to it.
- Written information of any costs of your care and treatment for which you may have to pay.
- Privacy about your care unless law permits disclosure.
- Consent for records to be released, unless the law specifically allows for it.
- See your records. Staff may limit what you see while you are receiving services. You must be told reasons for any limits. See your entire treatment record upon request after discharge.
- Challenge your records accuracy through the grievance process.
- Be informed of your rights and how to use the grievance process
- File a formal grievance without threat or penalty.

## You or your child is responsible to:

- Give truthful and complete health information.
- Tell the provider if you do not understand any part of your or your child's care.
- Help with your or your child's care as you have agreed to.
- Follow the care plan and instructions.
- Pay for bills for care provided.
- Follow the rules.
- Respect the rights of others including staff and property.
- Not take pictures or video of your child, other people or staff.
- Know that the use of tobacco, illegal drugs, alcohol, guns or weapons of any kind are not allowed.

## Grievance Resolution Stages

**Informal Discussion (Optional)**

- If you feel your rights have been violated you are encouraged to first talk with staff or management about any concerns you have.

**Grievance Investigation - Organization Level Review**

- File a grievance within 45 days of the time you become aware of the problem. We may grant an extension.
- We will investigate your grievance and attempt to resolve it.
- We will give you written communication within 30 days from the date you filed the formal grievance.
- If your concern has not been resolved you can escalate your concern for a final administrative review.

**County Level Review**

- If you are receiving services through county support you may appeal the organization's decision to the county agency director. You must make this appeal within 14 days of the day you receive the organizational decision.
- The county agency director must issue his or her written decision within 30 days after you request this appeal.

**State Level Review**

- You may appeal the organization and county level review to the state grievance examiner.
- You must appeal to the state grievance examiner within 14 days of receiving the decision from the previous appeal level.

State Grievance Examiner, DSL
P.O. Box 7851, Madison, WI 53707-7851
(608) 266-9369
dhs.wisconsin.gov/clientrights/contacts.htm

**Final State Review**

- Any party has 14 days after receipt of the written decision of the state grievance examiner to request a final state review by the administrator of the Division of Supportive Living or designee.

DSL Administrator, DSL
P.O. Box 7851, Madison, WI 53707-7851
(608) 266-9369
dhs.wisconsin.gov/clientrights/contacts.htm