Crisis Referral

General Member Info

Creation Date:		Member No:	
Member Name:		DOB:	
		Age:	
Street Address:		City:	
		Zip:	
County of Responsibility:		Phone #:	
Others Living with Member:			

Usual School/Work/Social Schedule:			
Sun		Thurs	
Mon		Fri	
Tues		Sat	
Wed			

Member's Mental Health/Medical Info

Current MH Dx: •

MH Provider Name(s)	Clinic	Address	Phone #

Medical Condition(s) of Concern: •

Medical Provider Name(s)	Clinic	Address	Phone #

Prescriptions-including PRNs (current as of date of plan and may not be accurate for the duration of the crisis plan)

☐ See Attached Medications List Dated: ☐ No Medications

Member is: ☐ Verbal ☐ Non-Verbal **Other communication preferences:**

Crisis Plan Info

Strengths (including people/positive approaches/ways to engage):	•
Needs:	•
Description of Potential Crisis:	•
Recommended Response/Treatment:	•

Rev. 10/28/2020

Crisis Referral

Approaches to Avoid:	•
Hx Previous Emergency Service Provisions:	•
Additional Helpful Info:	•

Every effort is made to carry out the requested interventions; however, please consider the following when developing a plan:

1. **Mobile Crisis staff may consist of one person working with occasional limited availability.**
2. **Unforeseen factors can change the course taken by Mobile Crisis (we cannot guarantee action according to plan).**
3. **Crisis staff cannot use restraints.**

Chapter 51:	☐ Yes	☐ No	**Expires:**	
Settlement Agreement:	☐ Yes	☐ No	**To:**	
Worker Assigned:	☐ Yes	☐ No	**Name:**	
Intercounty Agreement:	☐ Yes	☐ No	**County:**	
Involuntary Med Order:	☐ Yes	☐ No		
Protective Placement:	☐ Yes	☐ No		
	Where:			

Member Involved With			**ROI In Place**	
MCO	☐ Yes	☐ No	☐ Yes	☐ No
DSS	☐ Yes	☐ No	☐ Yes	☐ No
CSP	☐ Yes	☐ No	☐ Yes	☐ No
CCS	☐ Yes	☐ No	☐ Yes	☐ No
CST	☐ Yes	☐ No	☐ Yes	☐ No
CHIPS	☐ Yes	☐ No	☐ Yes	☐ No
JIPS	☐ Yes	☐ No	☐ Yes	☐ No

Additional Contact Info

Useful Contact Name(s)	Agency	Hrs Available	Address	Phone #
Managed Care Organization				
Collateral Agency Worker Name:				
Primary CM (Coordinating Services):				
Secondary CM (Coordinating Services):				
Guardian/POA (if applicable):				

Signatures

Primary Care Manager (person completing the form) Signature:		**Date:**	
Member Signature of Agreement with Above Listed Response/Treatment:		**Date:**	
Guardian Signature of Agreement with Above Listed Response/Treatment:		**Date:**	

☐ **See Accompanied Documents & Location:**

Wood County
WISCONSIN

HUMAN SERVICES DEPARTMENT

Inter-County Agreement

1.) Wood County Human Services Department is aware of and a party to the placement of consumer:
Name: Date of Birth:
Resident of: County
At the following facility or service doing business in Wood County:
Name: Phone:
Street Address:
City, State & Zip Code:
Facility Contact Person:

2.) By virtue of this agreement County, henceforth referred to as the Referring County, agrees to the application of the State Department of Health and Family Services Residency Manual and further understands that a referral to the above facility or service activates that policy.

3.) The Referring County is located at the following address:
Name: Phone:
Street Address:
City, State & Zip Code:
After-hour Phone:
Assigned Case Manager/County Contact:

4.) Services not offered as part of said facility or service and deemed clinically appropriate by either the Referring County or Wood County shall be the financial responsibility of the Referring County, to the extent the cost of service is not covered by Medicaid, other third-party insurance or private pay.

5.) Should the presence of Wood County Staff be required at staffing or legal proceedings in the consumer's Referring County, the Referring County agrees to reimburse Wood County for staff wages, fringe benefits and mileage costs at current Wood County rates.

6.) In the event that said consumer is detained in Wood County under the emergency detention provisions of Chapter 51 or 55, it is the responsibility of Wood County to notify the Referring County of the circumstances of the detention as soon as possible to include the following: date, time, actions leading to the detention, detention facility, probable cause hearing date and time if known and the clinical staff person responsible for the care and treatment of the individual at the detention facility. It is the responsibility of the Referring County to work collaboratively with the Wood County Corporation Counsel, the treatment team of the detention facility and Wood County staff to implement any court orders occurring as a result of the probable cause or final hearing proceedings. The Referring County assumes financial responsibility for mental health services/staff costs associated with the detention and any ancillary services (such as but not limited to transportation services, crisis bed charges, medical clearance charges, etc.) provided as a result of the detention itself, and as ordered by the court from the first day of the detention on. The Referring County further agrees to have the cost of said services billed directly to it.

7.) The Referring County agrees to submit to Wood County a crisis plan for the consumer within 72 hours of placement. An acceptable crisis plan sample can be provided upon request. Wood County reserves the right to request additional

information when it is deemed necessary and responses will be provided by the Referring County within 24 business hours.

8.) If acute psychiatric or detoxification services are needed by a consumer in Wood County, the individual will be placed at Norwood Health Center if possible. In the event placement at Norwood Health Center is not possible, arrangements will be made for a different hospital depending on availability.

9.) The Referring County acknowledges that the consumer identified in paragraph1 of this agreement has been and continues to be a resident of the Referring County irrespective of placement in a facility or receiving a service located in Wood County.

10.) Pursuant to Sec. 51.40(2)(f) Wisconsin Statutes, the Referring County recognizes that it bears full and sole responsibility for the care and provision of services, now and in the future for the consumer identified in paragraph 1 and that it shall not, at any time, claim or indicate that the consumer is a resident of Wood County or request or attempt to request a change in venue of any guardianship, protective placement or mental commitment proceeding to Wood County.

11.) In the event the Referring County's consumer terminates all services in Wood County, but continues to reside in Wood County, the Referring County agrees to maintain full financial and programmatic liabilities for all Chapter 51 services for a period of one (1) year beyond the termination of services.

12.) The statements and agreements of the parties herein form the consideration for each other.

13.) A copy, facsimile or e-mail of this document shall be as valid as an original.

14.) This agreement remains in effect as long as said consumer resides in Wood County.

IN WITNESS WHEREOF, the undersigned have executed and dated this agreement this day of ,

County

By: ______________________________

Wood County Human Services Department

By: ______________________________

Behavioral Health

WOOD COUNTY HUMAN SERVICES DEPARTMENT

Authorization for Use or Disclosure of Protected Health Information

Name of Client: ______________________________ DOB: _______________________

I hereby authorize the use and disclosure of my health information as indicated below. I understand that this release is voluntary and that I may revoke this authorization at any time except to the extent that action has been taken in reliance on this authorization. I also understand that if the individual or organization authorized to receive this information is not required to comply with current privacy regulations, my health information may be disclosed to others and no longer protected by current state and federal privacy regulations.

I authorize Wood County Human Services, 111 West Jackson Street, Wisconsin Rapids, WI 54495 to:

☐ **Disclose Information To:** ☐ **Receive Information From:** ☐ **Exchange Information With**

Name: ____
Address: ____
City, State & Zip: ______________________________________
Phone Number: ____
Fax Number: ____

I hereby authorize the release of the information checked and/or listed below for the time period beginning on _____________ and ending on _____________.

- ☐ Disclosure of Presence, appointment & counselors
- ☐ Mental Health Intake/Progress Notes
- ☐ AODA Intake/Progress Notes/OWI Assess/Eval
- ☐ Psychiatric/Psychological Testing
- ☐ Inpatient Hospitalization Records
- ☐ Medical History/Medical History
- ☐ Lab Results
- ☐ School and/or Employment
- ☐ Discharge Summary/After-care plan
- ☐ Legal History
- ☐ Background/Social History
- ☐ Academic Records/Progress
- ☐ Telephone Contact/Consultation
- ☐ Treatment Plan
- ☐ Permission to Audio/Video tape session
- ☐ Other: ______________________
- ☐ Other: ______________________

Purpose for Disclosure: ☐ Further Medical Care ☐ Personal Use ☐ Legal Issue

☐ Continuity of Beneficial Care ☐ Payment/Insurance ☐ Other (please describe): _________________________.

I understand that records are protected under the State Administrative Code, DHS 92, and federal regulations governing Confidentiality of Alcohol & Drug Abuse Patient Records, 42 CFR, part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations.

I understand that information may be disclosed as outlined in Wisconsin Statute 961.385 Prescription drug monitoring program.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.

I understand that I may inspect and copy any information used or disclosed under this authorization. I understand that a fee may be charged for such copying services.

I hereby release Wood County, its employees, officers, and health care professionals from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

I understand that I may revoke this request at any time by providing Wood County with my written notice of such revocation. A photo static copy or fax of this original and/or revocation shall be considered as valid as the original.

This authorization will remain in effect from the date this authorization is signed until the _____ day of_____________, 20_____ or a period of one year from the date this authorization was signed if not specified.

By signing this, you specifically authorize the use and disclosure of the information you selected above. You acknowledge that you have reviewed and understand this authorization form.

Date: _______________ Signature of Client: ______________________________
Printed Name of Client: ______________________________
Date: _______________ Signature of Representative: ______________________________
Printed Name of Representative: ______________________________
Relationship to Client: ______________________________

A copy of this record must be provided to the person making the request and a copy must be filed in the medical record.

Behavioral Health

WOOD COUNTY HUMAN SERVICES DEPARTMENT

Authorization for Use or Disclosure of Protected Health Information

Name of Client: ______________________________ DOB: ______________________

I hereby authorize the use and disclosure of my health information as indicated below. I understand that this release is voluntary and that I may revoke this authorization at any time except to the extent that action has been taken in reliance on this authorization. I also understand that if the individual or organization authorized to receive this information is not required to comply with current privacy regulations, my health information may be disclosed to others and no longer protected by current state and federal privacy regulations.

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☐ **Disclose Information To:** ☐ **Receive Information From:** ☐ **Exchange Information With**

Name: ____
Address: ____
City, State & Zip: ____
Phone Number: ____
Fax Number: ____

I hereby authorize the release of the information checked and/or listed below for the time period beginning on ____________ and ending on ____________.

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- ☐ Mental Health Intake/Progress Notes
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- ☐ Lab Results
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- ☐ Discharge Summary/After-care plan
- ☐ Legal History
- ☐ Background/Social History
- ☐ Academic Records/Progress
- ☐ Telephone Contact/Consultation
- ☐ Treatment Plan
- ☐ Permission to Audio/Video tape session
- ☐ Other: ____________________
- ☐ Other: ____________________

Purpose for Disclosure: ☐ Further Medical Care ☐ Personal Use ☐ Legal Issue

☐ Continuity of Beneficial Care ☐ Payment/Insurance ☐ Other (please describe): ______________________.

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Printed Name of Client: ________________________________
Date: ______________ Signature of Representative: ________________________________
Printed Name of Representative: ________________________________
Relationship to Client: ________________________________

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Rev 2/18

Behavioral Health

WOOD COUNTY HUMAN SERVICES DEPARTMENT

Authorization for Use or Disclosure of Protected Health Information

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