RAWHIDE YOUTH SERVICES

APPLETON · FOND DU LAC · GREEN BAY · GREATER MILWAUKEE
SHIOCTON · NEW LONDON
E7475 RAWHIDE RD., NEW LONDON, WI 54961-9052
PHONE 1-877-300-9101 FAX (920)982-5040 RAWHIDE.ORG

School-Based Mental Health Program Referral Form

Student's Name: _____ Date of Birth: _____

Address: _____ Phone Numbers: _____

_____ _____

School Attending: _____

Presenting Problems:

_____

_____

_____

_____

Goals for Treatment:

_____

_____

_____

_____

Payment Type:

☐ Private Insurance (Name of Ins. Co.) _____ ☐ Cash

☐ BadgerCare ☐ Other _____

Parent/Guardian Name: _____ Date of Birth: _____

Address (if different): Phone Numbers: _____

_____ _____

_____ Email Address: _____

Is the parent/legal guardian supportive of this referral? ☐ Yes ☐ No

Name of Foster Parent (if in foster care): _____

Address: _____ Phone Numbers: _____

_____ _____

_____ Email Address: _____

Referring Person:

Name: _____ Phone Numbers: _____

School or _____ _____

Agency: _____ Fax Number: _____

We must receive this completed form before we can discuss any information specific to this referral.

Parent/legal guardian must sign this form, giving us permission to contact them to set up an appointment for an assessment. A session will be scheduled after insurance coverage is verified or other payment options have been set up.

Please mail or fax this form to Rawhide Youth Service, Attn: Outpatient Counseling, E7475 Rawhide Road, New London, WI 54961. A follow-up call is appreciated to verify the referral has been received. Our fax number is **(920) 531-2686**. If you have any questions, please call us at **877-300-9101** or email us at **outpatient@rawhide.org**.

_____ _____

Parent/Guardian Signature Today's Date:

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CLIENT REGISTRATION FORM

Date:		Counselor:		Referred by:	

CLIENT INFORMATION

Last Name	First Name	M.I.	Date of Birth	Age	☐ Male ☐ Female ☐ Other

Street	City	State	Zip	County:

SS #: *Email:

Phone: Home: Work: Cell:

Religion: Primary Language Spoken: ☐English ☐Spanish ☐Other Marital Status: ☐Minor ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

Ethnicity: ☐African-American ☐Asian ☐Caucasian ☐Hispanic ☐Native American ☐Other: ☐ Military Dependent

Employed: ☐Full time ☐Part time ☐Unemployed ☐Homemaker ☐Retired ☐Student Employer:

*Email address for in-house use only. We will never share with any third party.

SPOUSE or LEGAL GUARDIAN(S)

First Name	First Name	M.I.	SS#	DOB	Age

Street	City	State	Zip

Phone: Home: Work Cell

☐ Emergency Contact ☐ Primary Custody ☐ Military Dependent
☐ Spouse ☐ Mother ☐ Father ☐ Other

Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

Employed: ☐Full time ☐Part time ☐Unemployed ☐Homemaker ☐Retired ☐Student Employer:

Last Name	First Name	M.I.	SS#	DOB	Age

Street	City	State	Zip

Phone: Home Work Cell

☐ Emergency Contact ☐ Primary Custody ☐ Military Dependent
☐ Mother ☐ Father ☐ Other

Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

Employed: ☐Full time ☐Part time ☐Unemployed ☐Homemaker ☐Retired ☐Student Employer:

Please list 3 things you (or your child) would like to change during treatment:

1.

2.

3.

Adult clients (as applicable): I authorize Rawhide Youth Services to discuss (check all that apply):

☐ Scheduling/canceling sessions ☐ Account balance and/or payments with _____
Relationship to client: ☐ Spouse/Significant Other ☐ Parent ☐ Child ☐ Other_____

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Client: Last Name	First Name	M.I.

PRIMARY INSURANCE COVERAGE

Policy Holder: Last Name	First Name	M.I.	Date of Birth	☐ Male ☐ Female ☐ Other

SS#:	Relationship to Client: ☐ Self ☐ Spouse ☐ Parent ☐ Other_____

Street	City	State	Zip

Phone: Home: Work Cell

Employer:

Ins. Co. Name:	Ins. Co. Phone#:

Claims Address:

Member/ID#:	Group#:

SECONDARY INSURANCE COVERAGE (if applicable)

Policy Holder: Last Name	First Name	M.I.	Date of Birth	☐ Male ☐ Female ☐ Other

SS#:	Relationship to Client: ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

Street	City	State	Zip

Phone: Home: Work Cell

Employer:

Ins. Co. Name:	Ins. Co. Phone#:

Claims Address:

Member/ID#:	Group#:

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BILLING & FEE AGREEMENT & WAIVER

Rawhide, Inc. (doing business as "Rawhide Youth Services," herein "Rawhide") is a licensed mental health provider. As a courtesy, Rawhide will submit claims to your insurance company, subject to the Terms and Acceptance set forth below. Please consult your insurance policy or contact your insurance company directly to be fully informed of your benefits and any limitations.

If you have a Co-pay or Deductible, it must be paid at the time of service. Please make checks payable to "Rawhide, Inc."

Our fees are usual and customary for master's degree-level professionals providing EAP, evaluation and psychotherapy services. These are our standard rates, but other rates may apply based on type and/or length of session:

Initial Evaluation Fee: $195	Group Fees: $140 (per 60-minute session)
Session Fees:	$130.00 (per 45-minute session) $173 (per 60-minute session) $195 (per 50-minute session with family only)

We require a minimum of 24-hour notification for appointment cancellations. If you need to cancel an appointment, please contact us at 877-300-9101 as soon as possible. **If you miss an appointment without notifying us 24 hours in advance of your scheduled time, you will be charged $75 for the missed appointment.**

TERMS AND ACCEPTANCE

I understand that, as a courtesy, Rawhide will submit claims to my insurance company for counseling services provided to my child, dependent, ward or me. I agree to provide all information reasonably required by Rawhide or my insurance company to permit processing of claims, and I hereby authorize payment of medical benefits to Rawhide. I also authorize Rawhide to furnish to insurance companies or their representatives necessary EAP evaluation and/or treatment information concerning my child, dependent, ward or me, as may be needed to complete claims processing for benefits.

I understand that not all services may be covered or authorized for payment by my insurance company, and I therefore agree that I will be personally liable for any portion of fees not paid by insurance. I will reimburse Rawhide for reasonable professional fees and related expenses if my account should be referred to a lawyer or agency for collection. I have been advised that Rawhide may discontinue services if my insurance company or I do not pay for services promptly.

By my signature below, I am giving voluntary consent for release of treatment information for billing purposes as related to my insurance benefits only. I am aware that this information may be sent by electronic means on a secured line and/or by paper claim form. I further understand that Rawhide shall endeavor to maintain, but cannot guarantee, the confidentiality of information disclosed via email and/or telephone.

Client Name (please print): _____

Responsible Party (please print): _____ Relationship: _____

Responsible Party (signature) Date:

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**Our normal business hours are 8:00 a.m. to 4:30 p.m., Monday through Friday.
If you have a mental health emergency during non-business hours, dial 911 for immediate help or go to your nearest emergency room. You may also contact your local county Crisis Center or refer to the procedures your counselor discussed with you.**

CLIENT RIGHTS

The State of Wisconsin provides that each individual in treatment has rights. These rights are pertinent to outpatient mental health clinics. (DHS 94.04)

TREATMENT RIGHTS

1. To receive prompt and adequate treatment.
2. As a voluntary patient, to refuse treatment or medication at any time.
3. To be free from unnecessary or excessive medication or drastic treatment.

COMMUNICATION/PRIVACY RIGHTS*

1. To refuse to be filmed or taped without your consent.
2. To have your treatment records and conversations about your treatment kept confidential.
3. To have access to your treatment record after discharge (or during treatment, if the facility director approves it).

***Note: In certain circumstances, communication with clients may take place via texting or email. Rawhide Youth Services makes every effort to maintain client confidentiality. However, the security of systems used for text and/or email communication cannot be guaranteed.**

CIVIL RIGHTS

1. No client is to be refused services on the basis of race, creed, color, religion, age, sex, or national origin (DHS 61.10-61.13).

RIGHT TO COMPLAIN

1. If you feel your rights have been violated, you have a right to use a grievance procedure. Please refer to the enclosed copy of "Client Rights and the Grievance Procedure for Community Services."

INFORMED CONSENT FOR TREATMENT

THE PROCESS OF TREATMENT

1. **Benefits of Treatment:** The benefits of therapy are to help the client meet his/her goals for treatment. These goals will be developed together with the counselor.
2. **Administration of Treatment:** The client and the counselor together determine how best to meet the goals of treatment. If the client does not think that his/her goals are being met, this should be discussed with the counselor for evaluation, re-contracting, or referral to a provider who may better meet the needs and goals of the client. If the counselor does not feel the clinic is able to meet the needs of the client, the client may be involuntarily discharged and given referral options to other providers better suited to the client's needs.

3. **Side Effects of Treatment:** Therapy helps the client work on his/her goals. In some cases this means that unhappy feelings may increase before things start to get better.
4. **Probable Benefits of Receiving Proper Treatment:** People who choose counseling to overcome their problems in living have a better advantage at making more appropriate life choices and decisions.
5. **Effective Time Period of Consent for Treatment:** The client's consent for treatment will last until the client either withdraws the consent and terminates treatment or the goals of treatment have been satisfactorily reached and the case is closed.
6. **Clinic's Grievance Policy:** There is a copy of the Grievance Procedure given to the client with the registration packet for the counselor to go over with the client.
7. **After Hours Emergency Procedure:** Client will be instructed by their counselor on how to obtain emergency services after normal business hours.

DISCHARGE FROM TREATMENT

A client may be discharged from treatment for any of the following reasons:
(DHS 35.18 (1) (k))

1. Completion of treatment goals
2. Referral to another therapist or more intensive treatment
3. Noncompliance with the course of treatment or violation of clinic rules
4. Repeated cancellations or missed appointments
5. No contact with therapist for at least 30 consecutive days
6. Inability to pay for services
7. Other reasons as determined by the counselor

A **Notification of Discharge** is sent to all clients who have been discharged from care. In most cases, a client may return to receive additional treatment as needed, provided the reasons for seeking treatment are within the scope of our licensing or clinic set up, and the counselor has available openings.

INVOLUNTARY DISCHARGE FROM TREATMENT

A client may be involuntarily discharged from treatment for either of the following reasons:
(DHS 35.24 (3) (a) (b))

1. Inability to pay for services
2. Behavior that is reasonably a result of mental health symptoms

Prior to the effective date of the involuntary discharge, a **Notification of Involuntary Discharge** will be sent to the client, which includes the following information:

1. Reasons for the discharge
2. Effective date of the discharge
3. Sources for further treatment
4. Consumer's right to have the discharge reviewed prior to the effective date of discharge

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ACKNOWLEDGEMENT OF CLIENT RIGHTS, INFORMED CONSENT FOR TREATMENT AND DISCHARGE POLICIES

The types of services I am requesting from Rawhide Youth Services have been explained to me. I voluntarily consent to become actively involved in the process of treatment. I have been offered a copy of the Grievance procedures**.**

It has been explained to me that normal business hours for Rawhide Youth Services are 8:00 a.m. to 4:30 p.m., Monday through Friday.

If I have a mental health emergency during non-business hours, I understand I should call the on-call counselor at 920-982-6100, then press 1, then 1 again and leave a message with detailed information about the crisis and the on-call counselor will return my call as soon as possible. If I feel I have an immediate need, I should dial 911 and/or go to my local emergency room. I may also contact my local county Crisis Center using the numbers given to me by my counselor.

I acknowledge that I have been offered a copy of and understand the Client Rights, Informed Consent for Treatment and the policies regarding Voluntary and Involuntary Discharge.

If applicable, I give permission for my child to receive evaluation and treatment by a counselor of Rawhide Youth Services.

Client Name (please print)

Client Signature (age 14 and older) Date

Parent or Guardian Signature (all minor clients) Date

Counselor Signature Date

HIPAA Release

(Health Insurance Portability and Accountability Act)

CONSENT TO USE OR DISCLOSE INFORMATION
FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS (TPO)

Federal regulations (HIPAA) allow us to use or disclose Protected Health Information (PHI) from your record in order to provide treatment to you, to obtain payment for the services we provide, and for other professional activities (known as "health care operations"). Nevertheless, we ask your consent in order to make this permission explicit. The Notice of Privacy Practices describes these disclosures in more detail. You have the right to review the Notice of Privacy Practices before signing this consent. We reserve the right to revise our Notice of Privacy Practices at any time. If we do so, the revised Notice will be available from this office. You may ask for a printed copy of our Notice at any time. You may ask us to restrict the use and disclosure of certain information in your record that otherwise would be disclosed for treatment, payment, or health care operations; however, we do not have to agree to these restrictions. If we do agree to a restriction, that agreement is binding. You may revoke this consent at any time by giving written notification. Such revocation will not affect any action taken in reliance on the consent prior to the revocation. This consent is voluntary; you may refuse to sign it. However, we are permitted to refuse to provide health care services if this consent is not granted, or if the consent is later revoked.

I hereby consent to the use and disclosure of my Protected Health Information as specified above.

Client Name (please print)

Client Signature (age 14 and older) Date

Parent or Guardian Signature (all minor clients) Date

Counselor Signature Date

A copy of this informed consent will be given to the client upon request.

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Use and Disclosure of Protected Health Information (PHI)
Rawhide Youth Services (hereafter referred to as Rawhide) may use your Protected Health Information for the purpose of providing treatment, obtaining payment for care and other related health care operation.

Circumstances Involving Use and Disclosure of Protected Health Information

To Provide Treatment
Rawhide may use your Protected Health Information to consult with Rawhide employees or designated treatment providers to provide the best quality of care. For example, a coordinating physician may need to know additional information about your symptoms to prescribe appropriate medications.

Payment
Rawhide may disclose your Protected Health Information to other parties involved in paying for your treatment or care.

Operations
Rawhide may use the minimum required Health Information for quality assessment activities, licensing, or statistical and accreditation purposes. For example, Rawhide's Outpatient Clinic Administrator is required to review charts for formatting and signatures in order to remain licensed through the State of Wisconsin.

Note-Psychotherapy notes are never released to anyone internally or externally for treatment, payment or operation.

When Required by Law
Rawhide will disclose your Protected Health Information when it is required to do so by Federal, State or Local law. This includes responding to a subpoena.

To Report Abuse or Neglect
Rawhide and its' employees are mandated by law to report suspected child abuse, either physical or sexual, and child neglect.

To Report a Serious Threat to Health or Safety
If an employee of Rawhide has good reason to believe that your safety is in jeopardy (for example, because of a suicide threat) or that another's safety is in jeopardy (for example, because of a threat to harm another), we are mandated by law to disclose Protected Health Information for the purpose of preventing harm to yourself or to someone else.

Use and disclosure for any purpose described above is limited to the minimum necessary information needed by a third party to carry out services that are in the best interest of the customer. The customer will be notified by Rawhide when a disclosure must be made in the above instances.

Authorization and Rights Regarding Your Health Information

Other than stated above, Rawhide will not disclose your Protected Health Information other than with your written authorization. If you authorize the agency to use your Protected Health Information, you may revoke the authorization in writing at any time.

You have the following rights regarding your health information:

1. Right to request restrictions on disclosure of your health information. We will respectfully consider your request, but there may be times when we are not required to agree to your request. (If disclosing information would jeopardize the customer or if the law requires disclosure.)
2. Right to inspect and copy your health information. You must request your health information in writing, signing your request, and allow the agency 72 hours to process your request.
3. Right to amend Protected Health Information. If you believe that your health care information is incorrect or incomplete, you may request to amend your record. Your request must be made in writing and be signed. We will respectfully consider your request, but there may be times when we are not required to abide by your request.
4. Right to an accounting of disclosures. You have the right to request an accounting of the disclosures that Rawhide makes of your health information.

Complaints

If you believe Rawhide has violated your privacy rights, you have the right to file a complaint in writing with your Client Rights Specialist. Send your complaint to Micki Fecteau, Outpatient Office Supervisor, Rawhide Youth Services, E7475 Rawhide Road, New London, WI 54961. Or contact the State Grievance Examiner, Division of Mental Health and Substance Abuse Services (DMHSAS), PO Box 7851, Madison, WI 53707-7851.

Effective Date

This notice is effective December 31, 2019, and replaces any previous notice of privacy practices issued by Rawhide.

Questions

If you have any questions regarding this notice, please contact the Outpatient Office Supervisor.

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Psychosocial History Questionnaire

Client Name: _____ Date: _____

Developmental History

Pregnancy/Delivery: [briefly describe your or your child's prenatal environment/development]

Smoking during pregnancy:	☐ No	☐ Yes	Amount	_____	
Alcohol during pregnancy:	☐ No	☐ Yes	Amount/type	_____	
Drugs during pregnancy:	☐ No	☐ Yes	Amount/type	_____	
Medications during pregnancy:	☐ No	☐ Yes	Details	_____	
Premature:	☐ No	☐ Yes	Weight	_____	

Milestones:

Motor Skills:	☐ Delayed	☐ On target	☐ Advanced
Language Development:	☐ Delayed	☐ On target	☐ Advanced
Social Skills:	☐ Delayed	☐ On target	☐ Advanced

Medical History:

Past or Current Illnesses/Disorders: [check all that apply]

☐ Allergies	☐ Diabetes	☐ Mononucleosis	☐ Vision problems
☐ Anemia	☐ Ear Infections	☐ Seizures	☐ Other _____
☐ Bed Wetting	☐ Epilepsy	☐ Strep	
☐ Concussion/TBI	☐ Lyme Disease	☐ Thyroid problems	

Have you had any surgeries? ☐ no ☐ yes Age: _____ Complications _____

Have you (or your child) received any of the following? (Check all that apply. Use back side if additional space is needed.)

☐ mental health counseling ☐ school counseling ☐ hospitalization ☐ psychological testing ☐ psychiatric services

Dates: _____ Provider Name: _____ Issue Treated: _____
Dates: _____ Provider Name: _____ Issue Treated: _____

Drug or Alcohol Rehabilitation ☐ No ☐ Yes Dates: _____ Where? _____

Issue(s) Treated: _____

Please list all medications you (or your child) are taking including prescriptions, over-the-counter, herbals, vitamins, or suspected illegal drugs (please use back side if additional space is needed) :

Name of Medication	Dosage	Dosage Frequency	Prescribing Doctor	Date Medication Started

Mother's Name: _____ _____ _____ _____

(Last) (First) (MI) Age

Educational Level: _____ Occupation: _____

Father: _____ _____ _____ _____

(Last) (First) (MI) Age

Educational Level: _____ Occupation: _____

Parents: ☐ Married ☐ Never Married ☐ Separated ☐ Divorced ☐ Deceased

Family/Social

Family History:

If client is under 18 years old:

Who has parental rights of the child? ☐ Mother ☐ Father ☐ Guardian (relationship): _____

Has either biological mom or dad had parental rights terminated or suspended? ☐ No ☐ Yes

If yes, when? _____

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

Child's current living arrangements: _____

CHILDREN or SIBLINGS (First & Last Name)	Age	Male/Female/ Other	Live with mom, dad, both, other

Family History of:

Substance Abuse: ☐ no ☐ yes details _____

Mental Illness: ☐ no ☐ yes details _____

Suicide: ☐ attempted ☐ completed details _____

Domestic Violence: ☐ no ☐ yes details _____

Educational

Highest Educational Level - Adults:
☐ High School ☐ Associates Degree ☐ Some College ☐ College Degree ☐ Graduate School

Highest Education Level - Minor:
Current Grade: _____ School: _____

Type of Placement: [check one or more]
☐ Special Education ☐ Regular classes ☐ Honors classes (G & T) ☐ Advanced Classes ☐ Home Study

Attitudes toward school: [check one or more]

☐ Truancy	☐ Argumentative	☐ Fighting with Peers
☐ Poor Effort	☐ Disruptive	☐ Attentive
☐ Repeated Grades	☐ Expulsions	☐ Suspensions
☐ Drugs/ETOH	☐ Difficulty with Peers	☐ Performance Problems

Describe any behavior problems, suspensions, or expulsions:

_____

Schools Attended:	***Dates Attended***

Client Name: _____
Date Completed: _____

Youth Outcome Questionnaire 30.1 PARENT REPORT (YOQ-30)

Purpose:
The YOQ-30 is designed to describe a wide range of troublesome situations, behaviors, and moods that are common in children and adolescents. You may discover that some of the items do not apply to your child's current situation. If so, please do not leave these items blank, but check the box under the "Never or Almost Never" category.

When you begin to complete the YOQ-30 you will see that you can easily make your child look as healthy or unhealthy as you wish. Please do not do that. If you are as accurate as possible it is more likely that you will be able to receive the help that you are seeking for your child.

Directions:

- Read each statement carefully.
- Decide how true this statement is for your child during the past 7 days.
- Check the box under the category that most accurately describes your child during the past week.
- You may select only one category per question.

	Never or Almost Never	Rarely	Sometimes	Frequently	Almost Always or Always
1. My child has headaches or feels dizzy.					
2. My child doesn't participate in activities that used to be fun.					
3. My child argues or speaks rudely to others.					
4. My child has a hard time finishing assignments or does them carelessly.					
5. My child's emotions are strong and change quickly.					
6. My child has physical fights (hitting, kicking, biting, or scratching) with family or others his/her age.					
7. My child worries and can't get things out of his/her mind.					
8. My child steals or lies.					
9. My child has a hard time sitting still (or has too much energy).					
10. My child uses alcohol or drugs.					
11. My child is tense and easily startled.					
12. My child is sad or unhappy.					
13. My child has a hard time trusting friends, family members, or other adults.					
14. My child thinks that others are trying to hurt him/her, even when they are not.					
15. My child has threatened to, or has run away from home.					
16. My child physically fights with adults.					
17. My child's stomach hurts or my child feels sick more than others his/her age.					
18. My child doesn't have friends, or doesn't keep friends very long.					
19. My child thinks about suicide or feels he/she would be better off dead.					
20. My child has nightmares, trouble getting to sleep, oversleeping, or waking up too early.					
21. My child complains about or questions rules, expectancies, or responsibilities.					
22. My child breaks rules, laws, or doesn't meet others expectations on purpose.					
23. My child feels irritated.					
24. My child gets angry enough to threaten others.					
25. My child gets into trouble when he/she is bored.					
26. My child destroys property on purpose.					
27. My child has a hard time concentrating, thinking clearly, or sticking to tasks.					
28. My child withdraws from family and friends.					
29. My child acts without thinking and doesn't worry about what will happen.					
30. My child feels like he/she doesn't have any friends or that no one likes him/her.					

*Client Name:*_____
Date Completed: _____

Youth Outcome Questionnaire 30.1 SELF REPORT (YOQ-30SR)

Purpose:
The YOQ-30SR is designed to describe a wide range of troublesome situations, behaviors, and moods that are common in children and adolescents. You may discover that some of the items do not apply to your current situation. If so, please do not leave these items blank, but check the box under the "Never or Almost Never" category.

When you begin to complete the YOQ-30SR you will see that you can easily make yourself look as healthy or unhealthy as you wish. Please do not do that. If you are as accurate as possible it is more likely that you will be able to receive the help that you are seeking.

Directions:

- Read each statement carefully.
- Decide how true this statement is for you during the past 7 days.
- Check the box under the category that most accurately describes you during the past week.
- You may select only one category per question.

	Never or Almost Never	Rarely	Sometimes	Frequently	Almost Always or Always
1. I have headaches or feel dizzy.					
2. I don't participate in activities that used to be fun.					
3. I argue or speak rudely to others.					
4. I have a hard time finishing assignments or I do them carelessly.					
5. My emotions are strong and change quickly.					
6. I have physical fights (hitting, kicking, biting, or scratching) with family or others my age.					
7. I worry and can't get things out of my mind.					
8. I steal or lie.					
9. I have a hard time sitting still (or I have too much energy).					
10. I use alcohol or drugs.					
11. I am tense and easily startled.					
12. I am sad or unhappy.					
13. I have a hard time trusting friends, family members, or other adults.					
14. I think that others are trying to hurt me, even when they are not.					
15. I have threatened to, or have run away from home.					
16. I physically fight with adults.					
17. My stomach hurts or I feel sick more than others my age.					
18. I don't have friends, or don't keep friends very long.					
19. I think about suicide or I feel I would be better off dead.					
20. I have nightmares, trouble getting to sleep, oversleeping, or waking up too early.					
21. I complain about or question rules, expectancies, or responsibilities.					
22. I break rules, laws, or don't meet others expectations on purpose.					
23. I feel irritated.					
24. I get angry enough to threaten others.					
25. I get into trouble when I am bored.					
26. I destroy property on purpose.					
27. I have a hard time concentrating, thinking clearly, or sticking to tasks.					
28. I withdraw from family and friends.					
29. I act without thinking and don't worry about what will happen.					
30. I feel like I don't have any friends or that no one likes me.					

- If you and the program manager agree with the CRS's report and recommendations, the recommendations shall be put into effect within an agreed upon time frame.
- You may file as many grievances as you want. However, the CRS will usually only work on one at a time. The CRS may ask you to rank them in order of importance.

Program Manager's Decision

If the grievance is not resolved by the CRS's report, the program manager or designee shall prepare a written decision within 10 days of receipt of the CRS's report. You will be given a copy of the decision.

County Level Review

- If you are receiving services from a county agency, or a private agency and a county agency is paying for your services, you may appeal the program manager's decision to the County Agency Director. You must make this appeal within 14 days of the day you receive the program manager's decision. You may ask the program manager to forward your grievance or you may send it yourself.
- The County Agency Director must issue his or her written decision within 30 days after you request this appeal.

State Grievance Examiner

- If your grievance went through the county level of review and you are dissatisfied with the decision, you may appeal it to the State Grievance Examiner.
- If you are paying for your services from a private agency, you may appeal the program manager's decision directly 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. You may ask the program manager to forward your grievance to the State Grievance Examiner or you may send it yourself. The address is: State Grievance Examiner, Division of Mental Health and Substance Abuse Services (DMHSAS), PO Box 7851, Madison, WI 53707-7851.

Final State Review

Any party has 14 days of receipt of the written decision of the State Grievance Examiner to request a final state review by the Administrator of the Division of Mental Health and Substance Abuse Services or designee. Send your request to the DMHSAS Administrator, P.O. Box 7851, Madison, WI 53707-7851.

You may talk with staff or contact your Client Rights Specialist, whose name is shown below, if you would like to file a grievance or learn more about the grievance procedure used by the program from which you are receiving services.

Your Client Rights Specialist is:

Micki Fecteau, Outpatient Office Supervisor
Rawhide Youth & Family Counseling
E7475 Rawhide Road
New London, WI 54961
877-300-9101

NOTE: There are additional rights within sec. 51.61(1) and DHS 94, Wisconsin Administrative Code. They are not mentioned here because they are more applicable to in-patient and residential treatment facilities. A copy of sec. 51.61, Wis. Stats. And/or DHS 94, Wisconsin Administrative Code is available upon request.

STATE OF WISCONSIN
DEPARTMENT OF HEALTH SERVICES
Division of Mental Health &
Substance Abuse Services
www.dhs.wisconsin.gov
P-23112 (12/2008)

Client Rights and the Grievance Procedure for Community Services*

for Clients Receiving Services in Wisconsin for Mental Illness, Alcohol or Other Drug Abuse, or Developmental Disabilities

*The term Community Services refers to all services provided in non-inpatient and non-residential settings.

CLIENT RIGHTS

When you receive any type of service for mental illness, alcoholism, drug abuse, or a developmental disability, you have the following rights under Wisconsin Statute sec. 51.61 (1) and DHS 94, Wisconsin Administrative Code:

PERSONAL RIGHTS

- You must be treated with dignity and respect, free from any verbal, physical, emotional or sexual abuse.
- You have the right to have staff make fair and reasonable decisions about your treatment and care.
- You may not be treated unfairly because of your race, national origin, sex, age, religion, disability or sexual orientation.
- You may not be made to work except for personal housekeeping chores. If you agree to do other work, you must be paid.
- You may make your own decisions about things like getting married, voting and writing a will, if you are over the age of 18, and have not been found legally incompetent.
- You may use your own money as you choose.
- You may not be filmed, taped or photographed unless you agree to it.

TREATMENT AND RELATED RIGHTS

- You must be provided prompt and adequate treatment, rehabilitation and educational services appropriate for you.
- You must be allowed to participate in the planning of your treatment and care.
- You must be informed of your treatment and care, including alternatives to and possible side effects of treatment, including medications.
- No treatment or medication may be given to you without your written, informed consent, **unless it is needed in an emergency** to prevent serious physical harm to you or others, or **a court orders it.** [If you have a guardian, however, your guardian may consent to treatment and medications on your behalf.]
- You may not be given unnecessary or excessive medication.
- You may not be subject to electro-convulsive therapy or any drastic treatment measures such as psychosurgery or experimental research without your written informed consent.
- You must be informed in writing of any costs of your care and treatment for which you or your relatives may have to pay.
- You must be treated in the least restrictive manner and setting necessary to achieve the purposes of admission to the program, within the limits of available funding.

RECORD PRIVACY AND ACCESS

Under Wisconsin Statute sec. 51.30 and DHS 92, Wisconsin Administrative Code:

- Your treatment information must be kept private (confidential), unless the law permits disclosure.
- Your records may not be released without your consent, unless the law specifically allows for it.
- You may ask to see your records. You must be shown any records about your physical health or medications. Staff may limit how much you may see of the rest of your treatment records while you are receiving services. You must be informed of the reasons for any such limits. You may challenge those reasons through the grievance process.
- After discharge, you may see your entire treatment record if you ask to do so.
- If you believe something in your records is wrong, you may challenge its accuracy. If staff will not change the part of your record you have challenged, you may file a grievance and/or put your own version in your record.
- A copy of sec. 51.30, Wis. Stats., and/or DHS 92, Wisconsin Administrative Code, is available upon request.

GRIEVANCE PROCEDURE AND RIGHT OF ACCESS TO COURTS

- Before treatment is begun, the service provider must inform you of your rights and how to use the grievance process. A copy of the Program's Grievance Procedure is available upon request.
- If you feel your rights have been violated, you may file a grievance.
- You may not be threatened or penalized in any way for presenting your concerns informally by talking with staff, or formally by filing a grievance.
- You may, instead of filing a grievance or at the end of the grievance process, or any time during it, choose to take the matter to court to sue for damages or other court relief if you believe your rights have been violated.

GRIEVANCE RESOLUTION STAGES

Informal Discussion (Optional)
You are encouraged to first talk with staff about any concerns you have. However, you do not have to do this before filing a formal grievance with your service provider.

Grievance Investigation—Formal Inquiry

- If you want to file a grievance, you should do so within 45 days of the time you become aware of the problem. The program manager for good cause may grant an extension beyond the 45-day time limit.
- The program's Client Rights Specialist (CRS) will investigate your grievance and attempt to resolve it.
- Unless the grievance is resolved informally, the CRS will write a report within 30 days from the date you filed the formal grievance. You will get a copy of the report.

III. AODA TREATMENT (continued)

C. **If you are 12 or older**, you can be provided some limited treatment without your parent or guardian's consent or knowledge.

IV. TREATMENT RIGHTS

A. You must be provided **prompt and adequate treatment.**

B. **If you are 14 years old or older**, you can **refuse treatment until** a court orders it.

C. You **must be told** about your treatment and care.

D. You have the right to and are encouraged to **participate** in the **planning** of your treatment and care.

E. Your relatives must be **informed of any costs** they may have to pay for your treatment.

V. PERSONAL RIGHTS

A. You must be **informed of your rights.**

B. **Reasonable decisions** must be made about your treatment and care.

C. **You cannot be treated unfairly** because of your race, national origin, sex, religion, disability or sexual orientation.

VI. RECORD ACCESS AND PRIVACY

A. Staff must keep your treatment information **private** (confidential). However, it is possible that your parents may see your records.

B. If you want to **see your records**, ask a staff member.

1. You may always see your records on any **medications you take.**

2. **Staff may limit** how much you may see of your other records. They must give you reasons for any limits.

C. If you are at least 14, you can consent to releasing your own records to others.

VII. PATIENT RIGHTS HELP

If you want to know more about your rights or feel your **rights have been violated**, you may do any of the following:

A. **Contact the patient rights staff** if you have any questions. Their contact information should be provided to you by the service provider,

B. **File a complaint**. Patient rights staff will look into your complaints. They will keep your complaints **private** (confidential); however, they may need to ask staff about the situation.

C. **Call Disability Rights Wisconsin** (DRW). They are advocates and lawyers who can help you with patient rights issues. Their telephone number is **(608) 267-0214** or **1 (800) 928-8778**.

STATE OF WISCONSIN
DEPARTMENT OF HEALTH SERVICES
Division of Mental Health and
Substance Abuse Services
P-20470B (12/2008)
www.dhs.wisconsin.gov

State of Wisconsin

RIGHTS OF CHILDREN AND ADOLESCENTS In Outpatient Mental Health Treatment

What every young patient needs to know to be aware of his/her legal rights.

I. OUTPATIENT TREATMENT CONSENT

A. **If you are less than 14 years old:**

A parent or your guardian must agree, in writing, to your receiving outpatient mental health treatment.

B. **If you are 14 years or older:**

1. You **and** your parent or guardian must agree to your receiving outpatient mental health treatment.

2. If you want treatment but your parent or guardian is unable to agree to it or won't agree to it, you (or someone on your behalf) can petition the county Mental Health Review Officer (MHRO) for a review.

3. If you do not want treatment but your parent/guardian does, the treatment director for the clinic where you are receiving your treatment must petition the MHRO for a review.

II. REVIEW BY MHRO AND/OR COURT

A. Each Juvenile Court appoints a MHRO for that county. A list of MHRO's by county is at: http://dhs.wisconsin.gov/clientrights/minors/MHRO.htm

B. The Juvenile Court must ensure that you are provided any necessary assistance in the petition for review.

C. The MHRO must inform your county of the petition for review.

D. If you request it and the MHRO thinks it is in your best interests, review by the MHRO can be skipped and the review will be done by the court.

E. If the MHRO does the review:

1. A hearing must be held within 21 days of the filing of the petition for review.

2. Everyone must get at least 96 hours (4 days) notice of the hearing.

3. To approve your treatment (against your will or despite the refusal of your parent/guardian) the MHRO must find that all these are true:

   a. The refusal of consent is unreasonable.
   b. You are in need of treatment.
   c. The treatment is appropriate and least restrictive for you.
   d. The treatment is in your best interests.

4. You and your parent/guardian will be informed of the right to a judicial review.

F. Judicial Review

1. Within 21 days of the MHRO's ruling (or if that review is skipped), you (or someone acting on your behalf) can petition the Juvenile Court for a judicial review.

2. If you do not want the treatment, the court must appoint you an attorney at least 7 days prior to the hearing.

3. If it is your parent/guardian who does not want the treatment and you do not already have a lawyer, the court must appoint you one.

4. A court hearing must be held within 21 days of the petition.

5. Everyone must get at least 96 hours notice of the hearing.

6. To approve your treatment (against your will or despite the refusal of your parent/guardian) the Judge must find that all these are true:

   a. The refusal of consent is unreasonable.
   b. You are in need of treatment.
   c. The treatment is appropriate and least restrictive for you.
   d. The treatment is in your best interests.

7. A court ruling does not mean that you have a mental illness.

8. The court's ruling can be appealed to the Wisconsin Court of Appeals.

III. AODA TREATMENT

A. **At any age,** if your parent or guardian agrees to it, you can be required to participate in treatment for alcohol or other drug abuse.

B. **If you are less than 12,** you may get limited treatment (like detox) without your parent or guardian's consent only if they cannot be found or you do not have one.