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

You are scheduled with _____ on _____ at _____ AM / PM

☐ Westhill Professional Park
446 Westhill Blvd., Ste. 6
Appleton, WI 54914

☐ Bank Five Nine
5555 N Port Washington Rd., Ste. 207
Glendale WI 53217

☐ 926 Willard Dr., Ste. 228
Green Bay, WI 54304

☐ Thompson Center
E7475 Rawhide Rd.
New London, WI 54961

☐ N5367 Mayflower Rd.
Shiocton, WI 54170

☐ N5682 Cty Rd K
Fond du Lac, WI 54937

☐ 2692 County Rd GG
Neenah, WI 54956

☐ 143 E Lincoln Ave.
Milwaukee, WI 53207

☐ _School: _____

Payment is due at the time of service for co-pays or session fees.

Please read, complete and sign the following paperwork as indicated.

Minors must have paperwork signed by a parent or legal guardian.

❑ **CLIENT REGISTRATION FORM** - Fill out completely.

❑ **Psychosocial History** – Fill out completely.

❑ **INSURANCE INFORMATION** - If applicable, complete the form, then sign and date at the bottom. Bring your insurance card to your first session for us to copy, or return a copy of the **front and back** of the card with your paperwork.

For Minors: Parent(s)/Legal Guardian(s) must be present for the First and Second Sessions

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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)

(1) Last 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:

(2) 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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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

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

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

DCF 154.08 Confidentiality of records. Screening questionnaires, testing results, and treatment records relating to this chapter may not be disclosed unless for purposes connected with the administration of the program unless disclosure is otherwise authorized by law or by written consent from the person who is the subject of the record. The department may establish administrative, physical, and technical safeguard procedures administering agencies may be required to follow to assure compliance with state and federal laws relating to public assistance program records, drug testing and treatment records, and medical records.

History: EmR1612: emerg. cr. eff. 3-17-16; CR 16-022: cr. Register July 2016 No. 727, eff. 8-1-16.

DCF 105.08 Confidentiality of records. Screening questionnaires, testing results, and treatment records relating to this chapter may not be disclosed unless for purposes connected with the administration of a work experience program unless disclosure is otherwise authorized by law or by written consent from the individual who is the subject of the record. The department may establish administrative, physical, and technical safeguard procedures administering agencies may be required to follow to assure compliance with state and federal laws relating to public assistance program records, drug testing and treatment records, and medical records.

History: EmR1523: emerg. cr., eff. 11-9-15; CR 15-091: cr. Register June 2016 No. 726, eff. 7-1-16.

I acknowledge that certain parts of my child's records may be protected from disclosure under federal and state statutes and regulations including 42 CFR, Part 2; the Health Insurance Portability and Accountability Act of 1996 (commonly known as "HIPAA") and implementing regulations; and Secs. 48.78 and 51.30 Wis. Stats.), and may not be disclosed without written consent (such as this Informed Consent and Authorization/Media Advertising form), unless otherwise provided by applicable law;

51.30 Drug and Alcohol Programs Informed Consent. An informed consent for disclosure of information from court or treatment records to an individual, agency, or organization must be in writing and must contain the following: the name of the individual, agency, or organization to which the disclosure is to be made; the name of the subject individual whose treatment record is being disclosed; the purpose or need for the disclosure; the specific type of information to be disclosed; the time period during which the consent is effective; the date on which the consent is signed; and the signature of the individual or person legally authorized to give consent for the individual.

DHS 92.03
(3) INFORMED CONSENT. Informed consent shall be in writing and shall comply with requirements specified in s. 51.30(2), Stats., and this subjection.
(a) Informed consent shall be valid only if voluntarily given by a patient who is substantially able to understand all information specified on the consent form. A guardian may give consent on behalf of the guardian's ward. If the patient is not competent to understand and there is no guardian, a temporary guardian shall be sought in accordance with s. 54.50, Stats.
(b) Informed consent is effective only for the period of time specified by the patient in the informed consent document.
(c) A copy of each informed consent document shall be offered to the patient or guardian and a copy shall be maintained in the treatment record.
(d) Each informed consent document shall include a statement that the patient has a right to inspect and receive a copy of the material to be disclosed as required under ss. DHS 92.05 and 92.06.
(e) Any patient or patient representative authorized under s. 51.30(5), Stats., may refuse authorization or withdraw authorization for disclosure of any information at any time. If this occurs, an agency not included under s. 51.30(4)(b), Stats., that requests release of information requiring informed consent shall be told only that s. 51.30, Stats., prohibit release of the information requested.

DHS 94.17 Confidentiality of records. All treatment records are confidential. A patient or guardian may inspect, copy and challenge the patient's records as authorized under s. 51.30, Stats., and ch. DHS 92.

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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: $214.50	Group Fees: $154 (per 60-minute session)
Session Fees:	$95.70 (per 30-minute session) $143 (per 45-minute session) $190.30 (per 60-minute session)

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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INSURANCE INFORMATION

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#:

In the event you have an account balance, please provide your invoice address:

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Client 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

Family/Social

Family History:

Mother's Name: _____ Age: _____
(Last) (First) (M.I.)
Educational Level: _____ Occupation: _____

Father: _____ Age: _____
(Last) (First) (M.I.)
Educational Level: _____ Occupation: _____
Parents: □ Married □ Never Married □ Separated □ Divorced □ Deceased

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***
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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CLIENT RIGHTS

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.

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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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 Joel Walker, 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 September 30th 2021, 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.

- 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 Care and Treatment Services (DCTS), 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 Care and Treatment Services or designee. Send your request to the DCTS 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:

Joel Walker
920-531-2562

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 Care and Treatment Services
www.dhs.wisconsin.gov
P-23112 (09/2016)

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.