Milwaukee County DHHS-BHD
Children's Community Mental Health Services and Wraparound Milwaukee

Children's Mobile Crisis
CONSENT FOR TREATMENT

I, _____, as Parent/Guardian of
(please print)

_____
(Child's name) DOB

authorize Children's Mobile Crisis and/or its contracted Crisis Service providers to:

_____ a. Provide Crisis Intervention for the above-named child.

_____ b. Voluntarily transport the above-named child.

_____ c. Secure necessary emergency medical (physical/mental health) care for the above-named child and transport to such services, as needed.

Unless otherwise specified, this Consent will expire 12 months from the date it was signed. This consent or any part of this consent may be canceled at any time with written notification.

RELEASE OF INFORMATION

I authorize Children's Mobile Crisis and/or its contracted Crisis Service providers to release / exchange health related and billing data with any and all private or public health care insurers, reimbursement agencies, third party payers of the above-named child for all treatment services provided. By law, this information can also be shared with the State of Wisconsin Department of Children and Families.

ASSIGNMENT OF BENEFITS

I hereby assign payment directly to Milwaukee County DHHS-BHD Children's Community Mental Health Services and Wraparound Milwaukee for the benefits otherwise payable to me by any third party, including transitional benefits, but not to exceed the regular charges for mobile emergency mental health treatment.

RECEIPT OF CLIENTS RIGHTS ACKNOWLEDGEMENT

I have received and understand my rights as a participant of Children's Mobile Crisis.

NOTICE OF PRIVACY PRACTICES

I have received and understand Children's Mobile Crisis Privacy Statement.

(Check only if applicable)
☐ Client/guardian declines copy of Privacy Practices Notice.

Signature of Parent/Guardian_____ Date Signed_____

Relationship to Client_____

Signature of Client_____ Date Signed_____
(Youth age 14 and older **MUST** sign)

Signature of Witness_____ Date Signed_____

YOUR RIGHTS WITH RESPECT TO THIS CONSENT:

Right to Refuse to Sign This Consent/Acknowledgement Form - I understand that I am under no obligation to sign this form and that Children's Community Mental Health Services and Wraparound Milwaukee may not condition treatment, payment, or enrollment on my decision to sign this authorization.

Right to Withdraw This Consent - I understand that I have the right to withdraw consent for any of the items identified on this Consent at any time by providing a written statement of withdrawal to Children's Community Mental Health Services and Wraparound Milwaukee Quality Assurance Department. (The written statement must identify what Consent is being withdrawn, be dated and signed.) I am aware that my withdrawal will not be effective until received by Children's Community Mental Health Services and Wraparound Milwaukee.

Submit your written request for withdrawal to:

Quality Assurance Manager
Children's Community Mental Health Services and Wraparound Milwaukee
9455 Watertown Plank Road
Milwaukee, WI 53226
Phone: (414) 257-7595

ATTENTION: If you speak English, language assistance services are available to you free of charge. Call your Care Coordinator directly or call 1-833-912-2468 (TTY: 711)

Español (Spanish) - ATENCIÓN: Si habla español, tenemos servicios de asistencia lingüística disponibles de forma gratuita. Llame a su coordinador de atención directamente o bien llame al 1-833-912-2468 (TTY: 711)

Hmoob (Hmong) - CEEB TOOM: Yog koj hais lus Hmoob, muaj cov kev pab txhais lus pub dawb rau koj. Hu xov tooj ncaj nraim rau koj tus Neeg Khiav Hauj Lwm Muab Kev Kho Mob los yog hu rau 1-833-912-2468 (TTY: 711)

မြန်မာ (Myanmar)(Burmese) - အထူးသတိပြုပီရန် - အကယ်၍ ပြမန်မာဘာသာစကားကို သင်ပြောဆိုနိုင်ပါက ဘာသာစကားဆိုင်ရာ ဝန်ဆောင်မှုများကို အခမဲ့ သင် ရရှိနိုင်ပါသည်။ သင့် စောင့်ရှောက်မှု ဆက်စပ်ဆောင်ရွက်ပေးသူထံသို့ တိုက်ရိုက် ဖုန်းခေါ်ဆိုပါ သို့မဟုတ်လည်း 1-833-912-2468 (TTY: 711) သို့ ခေါ်ဆိုပါ