MILWAUKEE COUNTY
BEHAVIORAL HEALTH DIVISION
COMMUNITY SERVICES BRANCH

SERVICE ACCESS TO INDEPENDENT LIVING (SAIL)

9201 W. Watertown Plank Road Milwaukee, WI 53226 (414) 257-8095 Fax: (414) 454-4242

Milwaukee County Community Services Branch proudly serves Milwaukee County residents ages 18-59 who are living with a severe and persistent mental illness which affects their ability to function successfully in the community. Thank you for considering our community-based services. Before proceeding with the SAIL referral, please review and complete the following checklist, which clarifies our target population.

- ☐ Is the client a Milwaukee County resident?
- ☐ Is the client between the ages of 18 and 59?

  If age 60 and over, a referral must first be made to the Aging Resource Center of Milwaukee County (414.289.6874). Please include a copy of the determination letter indicating Family Care ineligibility with the SAIL referral.

  If under age 18, the client must be enrolled in Project O'YEAH or Wraparound/REACH. Please include a copy of the Plan of Care with the SAIL referral.

- ☐ Does the client have a severe and persistent mental illness that interferes with their ability to live successfully in the community?

  A severe and persistent mental illness is severe in degree and persistent in duration, resulting in a substantially diminished level of functioning in the primary aspects of daily living and difficulty coping with the ordinary demands of life. This may further lead to challenges in maintaining stability and independent functioning, requiring long-term treatment and support.

If the individual being referred meets the target population, please proceed with completion of the SAIL referral. Please note that in addition to completing the referral form, the following supporting documentation is required:

- Current and all previous psychiatric/psychological assessments/evaluations
- Current hospitalization initial assessment/records, if applicable
- Copies of hospital and treatment discharge summaries
- Current outpatient provider assessments and case notes

We are here to help with this process. For questions and further assistance, please call 414.257.8095.

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Date: _____ Name: _____ DOB: _____

Address: _____ Zip _____

Telephone _____ Alternate _____

SSN: _____ Sex: ☐M ☐F Marital Status: _____

Diagnosis: Axis I _____

Axis II _____

Axis III _____

Current service providers (Please include name, agency and phone number.)

Psychiatrist _____

Case Manager _____

Therapist _____

Other _____

SAIL Services Requested: ☐ Day Treatment ☐ Case Management- TCM

☐ Case Management –CSP ☐ CBRF (Group Home)

Insurance: Please include copy of card if applicable.

☐ None ☐ T-18/T-19 Pending

☐ T-18 (Medicare #) _____ ☐ T-19 (Medicaid #) _____

☐ HMO (Name and #) _____

☐ Private Insurance (Name and Group/Policy #) _____

☐ Veteran's Benefits _____

Income: Amt/Mo: _____ ☐SSI ☐SSD ☐Wages ☐Pension ☐Other _____

SSI/SSD Application Status: ☐Pending ☐Appeal ☐Winged Victory Referral

Payee: _____ Relationship/Agency: _____ Phone: _____

Legal Status (Check all that apply): ☐Voluntary ☐Chapter 51 ☐Chapter 55/880

☐Parole/Probation ☐Pending Criminal Charges

Please explain: (i.e., Stipulations, Commitment, Guardian) Attach copy of the order if applicable.

_____

Referent's Interim Care Plan (Provider, Location, Frequency): _____

Form Completed By: _____ Date: _____

Agency Name: _____ Phone: _____

Address: _____ Fax: _____

Email: _____ Relationship to Client: _____

CSB USE ONLY- Medical Record Number: _____

I. CLIENT PREFERENCES

Please indicate the client's preferences for community services, in their own words.

_____

_____

Please indicate any cultural needs of the client:_____

_____

II. STRENGTHS

Please list the client's strengths:_____

_____

III. RISK FACTORS

List problems that place client or others at risk based on past or current status. Include history of self-harm, vulnerability, violence, or criminal activity. _____

_____

_____

IV. MENTAL HEALTH

What is the client's understanding of his/her illness and motivation for treatment? _____

_____

_____

Briefly describe history of inpatient and outpatient treatment:_____

_____

_____

_____

If presently hospitalized, where, & date of admission: _____

If presently hospitalized, anticipated date of discharge: _____

Current prescribed medications: _____

_____

_____

_____

Please indicate one of the following:

- ☐ Generally takes medications as prescribed
- ☐ Often does not take medications as prescribed
- ☐ Usually does not take medications as prescribed

V. SUBSTANCE USE

List history, types, frequency, treatment, and current substance use: _____

_____

_____

_____

VI. TRAUMA

Does the client have a history of physical, sexual, verbal and/or emotional abuse? Please describe.

_____

_____

_____

Describe any trauma treatment and its outcome.

_____

_____

VII. PHYSICAL/MEDICAL HEALTH

Current providers (Please include name and phone number.)

_____

List conditions and/or disabilities: _____

_____

_____

Describe any assistance the client requires to facilitate care (including adaptive devices).

_____

_____

VIII. COMMUNITY LIVING SKILLS

Please indicate if problems arise in any of the following areas:

☐ Hygiene	☐ Housekeeping	☐ Shopping
☐ Dress	☐ Money Management	☐ Laundry
☐ Cooking	☐ Transportation	☐ Reading

1. Does the client experience difficulty in day-to-day activities secondary to his/her mental illness? If yes, please describe in detail. _____

_____

2. Indicate the client's daily activities, including involvement with employment, psychosocial clubs, partial hospitalization, DVR, etc.:_____

IX. HOUSING

Check the client's community living arrangement:

☐ lives alone

☐ lives with others Specify: _____

☐ homeless and living: ☐ in a shelter ☐ on street

Housing is: ☐ rented ☐ owned

Cost: $_____/month ☐ Subsidized?

If housing problems exist, please specify (include history of evictions, homelessness, etc.):

X. SOCIAL SUPPORTS (Community and natural supports)

	Name	Relationship	Support Provided
☐ Yes			
☐ No	List support needs		

XI. ADDITIONAL COMMENTS

CONSENT FOR TREATMENT – GENERAL

In consideration of treatment to be rendered to me by the Milwaukee County Behavioral Health Division Service System, Inpatient Services, Psychiatric Crisis Service, Outpatient Services, or contracted community services, I hereby consent to such care and treatment as may be deemed proper in the judgment of the clinical staff of the Milwaukee County Behavioral Health Division.

CONSENT FOR TREATMENT – PSYCHIATRIC CRISIS SERVICE

I, the undersigned, do hereby authorize and consent to any services of an emergency nature, including but not limited to psychiatric interview and other diagnostic procedures, laboratory procedures, medical, and other hospital services which are deemed necessary or advisable to by the attending physician(s) and rendered to me under the general or special instructions of said physician(s).

I acknowledge that the care which will be furnished to me in the Psychiatric Crisis Service Center in the Milwaukee County Behavioral Health Division will be limited solely to emergency treatment. I understand that I may be released before all of my medical or psychiatric problems are known or treated, and that it will be necessary for me to make arrangements for follow-up care. I do also hereby release the Milwaukee County Behavioral Health Division, all of its agents, employees and attending physician(s) from responsibility for anything but such emergency treatment.

RELEASE OF INFORMATION

I, further consent that the Milwaukee County Behavioral Health Division and contract agencies may disclose any medical record or billing data to any and all public or private health care insurers, reimbursement agencies, third party payers, and funding sources providing health care insurance of reimbursement to or on behalf of the patient, including but not limited to Medicare, Medicaid, Milwaukee County Department of Human Services, for the purpose of reimbursement, for all episodes of treatment during the next three years. In the event that my HMO/insurance determines that inpatient care should be provided at a facility of their choosing, I authorize Milwaukee County Behavioral Health Division to provide information to the receiving facility for the purpose of coordinating my continued care. I also authorize the Milwaukee County Behavioral Health Division to notify my primary care physician of my hospitalization when required by my insurance provider. I understand the specific type of information to be disclosed includes diagnosis, prognosis, and treatment for physical illness, and where applicable, mental disorders, alcohol or drug abuse, HIV test/results or AIDS, or any AIDS related diagnosis. This consent for release of information is subject to revocation at any time except to the extent that action has been taken in reliance thereon and, in any event, will expire when final payment for these services have been made, but in any case it is not to exceed three years. I authorize such disclosure with the further understanding that any written information disclosed under the conditions of this document will be accompanied when applicable by the following notice: "This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42CFR, Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose."

I further authorize the Division and its contractual agencies free exchange of information for the purpose of continuing care and health services review. I further authorize the Milwaukee County Behavioral Health Division to use the information regarding my care and treatment in conjunction with any and all educational training programs under affiliation agreements, and to the extent necessary to obtain and/or maintain licensure, accreditation, or certification.

ASSIGNMENT OF BENEFITS

I, hereby assign payment directly to the above named Division for the benefits otherwise payable to me by any third party, including major medical benefits, but not to exceed the regular charges for this period of hospitalization/emergency treatment/outpatient treatment. I (we) understand I am (we are) financially responsible for any regular charges not paid by said third party.

NOTICE OF DISCLOSURE

Information from your medical record will be shared, as permitted by law, with the State of Wisconsin Department of Health and Family Services.

NOTICE OF PRIVACY PRACTICES

I acknowledge that the Behavioral Health Division has provided me a copy of its Notice of Privacy Practices.

☐ Patient **declines** copy of Privacy Practices Notice. ☐ Patient **declines** to sign form.

Patient's Signature (including minors over 14)	Date/Time	Witness Signature	Date/Time
Patient's Agent, Parent, or Guardian's Signature	Date/Time	Relationship	

Addressograph or Name and BHD Number

MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION
CONSENT FOR TREATMENT, RELEASE OF INFORMATION
ASSIGNMENT OF BENEFITS, NOTICE OF DISCLOSURE

6452 R20
Rev. 12/10

MEDICAL RECORD

Requester: Fill Out to Receive Requested Information Expeditiously.

Notify: _____

Location: SAIL DEPT

NOTE: THIS FORM IS TO BE USED TO **OBTAIN** MEDICAL RECORD INFORMATION **FROM** OTHER AGENCIES.

_____ _____

Patient's Name Date of Birth

I hereby request and authorize: _____

_____

_____

to release information to: Milwaukee County Behavioral Health Division
9455 Watertown Plank Road
Milwaukee, WI 53226

The purpose for releasing these records is _____

I understand that the information may include diagnosis, prognosis, and/or treatment for physical illness, mental disorders, alcohol or drug abuse, any HIV test results and/or AIDS-related diagnosis.

The specific and relevant information I wish to release is:

_____ Discharge Summaries

_____ PCS Intake

_____ History & Physical

_____ Psychiatric/Psychological Evaluations

_____ Social Service Data Bases

_____ Treatment Plans

_____ Lab/Radiology

_____ Outpatient Assessments/Evaluations

_____ Outpatient Progress Notes/Treatment Plans

_____ Other (specify) _____

for the treatment period of (list approximate dates): _____

I understand that I may revoke this consent at any time by written notification except to the extent that action has been taken in reliance on it, and that in any event, this consent will expire one year from the date of signature unless an otherwise stated date, event or condition is stated here _____

A photocopy or facsimile of this authorization shall be as valid as the original.

PROHIBITION ON DISCLOSURE (for Alcohol and Drug Abuse records): This information is protected by Federal confidentiality rules (42 CFR, Part 2). The Federal rules prohibit making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute an alcohol or drug abuse patient. I also understand that I may inspect and, upon payment of the usual fee, receive a copy of the released information, and that I may receive a copy of this intended consent form.

Conditions: This authorization is voluntary. BHD will not condition your treatment on this authorization.

Effect of Granting This Authorization: The protected health information described above may be disclosed and/or received by persons or organizations that are not health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws. They may further disclose the protected health information, and it may no longer be protected by federal health information privacy laws.

_____ _____

Signature of Patient Person Authorized To Consent For Patient

_____ Date: _____

Date

_____ Relationship _____

Witness (Legal documentation of relationship required)

Reason: _____

BEHAVIORAL HEALTH DIVISION
Milwaukee, Wisconsin 53226

2190 RE
Rev. 01/06

CONSENT FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

NOTE: THIS FORM IS TO BE USED TO **RELEASE** MEDICAL RECORD INFORMATION **FROM** THE BEHAVIORAL HEALTH DIVISION

Patient's Name _____ Date of Birth _____

I hereby request and authorize: Milwaukee County Behavioral Health Division
9455 Watertown Plank Road
Milwaukee, WI 53226

to release information to: _____

_____

_____

The purpose for releasing these records is _____

I understand that the information may include diagnosis, prognosis, and/or treatment for physical illness, mental disorders, alcohol or drug abuse, any HIV test results and/or AIDS-related diagnosis.

The specific and relevant information I wish to release is:

_____ Discharge Summaries
_____ PCS Intake
_____ History & Physical
_____ Psychiatric/Psychological Evaluations
_____ Social Service Data Bases
_____ Treatment Plans
_____ Lab/Radiology
_____ Outpatient Assessments/Evaluations
_____ Outpatient Progress Notes/Treatment Plans
_____ Other (specify) _____

for the treatment period of (list approximate dates):_____

I understand that I may revoke this consent at any time by written notification except to the extent that action has been taken in reliance on it, and that in any event, this consent will expire one year from the date of signature unless an otherwise stated date, event or condition is stated here _____

A photocopy or facsimile of this authorization shall be as valid as the original.

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_____ Signature of Patient

_____ Person Authorized To Consent For Patient

_____ Date

Date: _____

_____ Witness

Relationship _____
(Legal documentation of relationship required)

Reason: _____

BEHAVIORAL HEALTH DIVISION
Milwaukee, Wisconsin 53226

2194 R11
Rev. 01/06

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION