1220 W. Vliet St., Milwaukee, WI 53205 Phone: (414) 257-8085 Fax: (414) 454-4242

Eligibility Determination Form

Milwaukee County Community Access to Recovery Services (CARS) proudly serves Milwaukee County residents who are living with a severe and persistent mental illness and/or substance abuse problem which affects their ability to function successfully in the community. Thank you for considering our community-based services. Before proceeding with the CARS referral, please review and complete the following checklist, which clarifies our target population.

The client is a Milwaukee County resident over the age of 18.

The client does not meet any of the following criteria:

Intellectual Disability
Physical Disability
Frail Elder
Alzheimer's Disease or other irreversible Dementia

If the client meets any of the above criteria, a referral must first be made to the Aging Resource Center of Milwaukee County (age 60 and over) 414.289.6874 or the Disability Resource Center of Milwaukee County (age 18-59) 414.289.6660.
Please include a copy of the determination letter indicating Family Care ineligibility with the CARS referral.

The client has a severe and persistent mental illness and/or substance abuse issue that interferes with their ability to live successfully in the community.

The client's income is at or below 200% of the Federal Poverty Level.

If the individual being referred meets the target population, please proceed with completion of the CARS referral. Please note that in addition to completing the referral form, the following supporting documentation will expedite the process and is very helpful during the assessment:

- Current and 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 414.257.8085. Fax completed forms to 414.454.4242.

MILWAUKEE COUNTY BEHAVIORAL HEALTH SERVICES COMMUNITY ACCESS TO RECOVERY SERVICES REFERRAL FORM

1220 W. Vliet St., Milwaukee WI 53205

Phone: (414) 257-8095 Fax: (414) 454-4242

Date: ____________ Client Name: ____________________________ DOB:___________

SSN: _____________ Gender Identity: ______________________________________

Address: ____

Telephone: ____

Insurance:

☐ None ☐ T-18 (Medicare) ☐ HMO ☐ Private Insurance

☐ T-19 (Medicaid) ☐ Veteran's Benefits

Please include Medicaid/Medicare # and/or Policy number, when applicable:

____

Income: Amount/Month:_________ ☐SSI ☐SSD ☐Wages ☐Pension ☐Other:_________

SSI/SSD Application Status: ☐Pending ☐Appeal

Payee: _______________ Relationship/Agency:_______________ Phone:_____________

Is the person under court orders (or negotiated settlement) for treatment? ☐ Yes ☐ No

Does the client have a Guardian/Protective Placement? ☐ Yes ☐ No

Guardian Name and Contact Information:____

Referrer Information

Form Completed By (Referrer Name):____________________ Date Completed:__________

Referrer's relationship to Client:____

Referrer Agency Name:____

Referrer Address:____

Referrer E-Mail:____

Referrer Phone: ____

For Office Use Only - MR#: ______________________

I. CLIENT PREFERENCES

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

II. BEHAVIORAL HEALTH AND ADDICTIVE DISORDERS HISTORY

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

If presently hospitalized, where:____

Date of Admission: ____

Anticipated Date of Discharge: ____

List all of the prescribed medications for mental health & substance use issues.

Mental health and substance abuse diagnoses and other relevant information such as risk factors, trauma, physical/medical health, housing, etc.

MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION (BHD) CONSENT FORM

____ ______________________________

Patient's Name Date of Birth

CONSENT FOR TREATMENT: *GENERAL*

I, the undersigned, do hereby authorize and consent to any services rendered to me by the Milwaukee County Behavioral Health Division Service System, including, but not limited to, Inpatient Services, Outpatient Services, the Community Services Branch, the Community Access to Recovery Services (CARS), and Wiser Choice Alcohol and Drug Abuse (AODA) Treatment Services. I hereby consent to such care and treatment as may be deemed proper in the judgment of the clinical staff of BHD.

CONSENT FOR TREATMENT: *PSYCHIATRIC CRISIS SERVICES (PCS)*

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 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 PCS 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 BHD, all of its agents, employees, and attending physician(s) from responsibility for anything but such emergency treatment.

BILLING & ASSIGNMENT OF BENEFITS

I hereby permit billing by and assign payment directly to BHD 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 understand that I am financially responsible for bills from BHD, including any regular charges not paid by a third party.

NOTICE OF DISCLOSURE

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

NOTICE OF PRIVACY PRACTICES

I acknowledge that BHD has provided me a copy of its Notice of Privacy Practices. Patient Declines. ☐

RELEASE OF INFORMATION

I, further authorize BHD and its contractual agencies free exchange of information for the purpose of continuing care and health services review. I further authorize BHD 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.

____

Patient's Signature (including minors over 14) Date/Time Patient Declines. ☐

____

Patient's Agent, Parent, or Guardian's Signatures Date/Time Patient Declines. ☐

MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION (BHD)
AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL INFORMATION

1. ____ ______________________________
Client/Patient Name Date of Birth

2. Name of Agency/Organization Authorized to Release Information to BHD:
____

3. Name of Agency/Organization Authorized to Receive Information from BHD:
____

4. Two-Way Exchange of Information: I authorize this information to be released between the designated organizations. Yes ☐ No ☐

5. Type of Information and Records Authorized for Release: All medical records related to (specify condition, treatment, etc.): ___________________________ for date period of ______ to _______ for the following records:

☐ HIV Test Results/AIDs–related Diagnosis
☐ History & Physical
☐ Social History
☐ Psychiatric/Psychological Evaluations
☐ Mental Status Examinations
☐ Psychometric Assessments
☐ Substance Use Assessments
☐ Rehabilitative Assessments
☐ Medical Orders
☐ Medication Administration Records
☐ Treatment Plans
☐ Individual Education Plans
☐ Progress and Therapy Notes
☐ Progress Notes Related to AODA
☐ Lab and Diagnostic Test Results
☐ Court Orders
☐ Reports from Other Agencies
☐ Discharge Summary
☐ Other: ___________________

6. Effective Dates of Authorization. This authorization will expire 12 months from the date of signature.

7. Revocation. Authorization may be revoked by submitting a written notice of revocation effective the date of the written notice. Revocation does not apply to information released before the revocation notice.

8. Purpose and Use of Information Disclosed: I authorize the above named agency/organization to disclose the above indicated information for the purposes of coordinating services for me. I understand that my information may be re-disclosed pursuant to this release to establish my eligibility for programs or benefits or to coordinate my services.

9. Prohibition on Disclosure for Alcohol and Drug Abuse Records: Alcohol and drug abuse records are protected by Federal confidentiality rules, 42 CFR, Part 2, the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. Parts 160 & 164, Wis. Adm. Code §§ HFS 92.05 and 92.06, and Wis. Stat. § 51.30. The Federal rules prohibit making any further disclosure of drug and alcohol abuse records unless expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, Part 2. The Federal rules restrict any use of such information to criminally investigate or prosecute an alcohol or drug abuse patient.

10. Signature. I authorize the use and/or disclosure of my confidential information. I may receive a copy of this consent form. I may also inspect, and upon payment of the usual fee, receive a copy of the released information.

____ ______________________________
Signature Date