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

Consent/Acknowledgement Form

Enrollee's Name: ________________________________ Date of Birth: ____________

The following items are essential to the care of you and/or your family while participating in Milwaukee County Children's Community Mental Health Services and Wraparound Milwaukee and its affiliated programs. Please review each area and indicate which areas you approve by initialing the appropriate box after each item.

	Initial to Approve
Acknowledgement of Receipt of Client Rights & Grievance/Appeal Procedure I have read and understand my legal client rights as a participant and/or as a guardian of a participantof Children's Community Mental Health Services and Wraparound Milwaukee Program and recipient of services provided through the Provider Network. By signing below, I acknowledge that I have received a copy of the "Client Rights and Grievance/Appeal Procedure" handout.	
Acknowledgement of Receipt of Privacy Statement I have received, read and understand the Privacy Statement, and understand the program's commitment to protecting any identifiable client information as mandated by law.	
Consent for Transportation I hereby give my consent for me and/or my children to be transported by Milwaukee County Children's Community Mental Health Services and Wraparound Milwaukee Program staff and its agents as needed.	
Emergency Medical/Mental Health Care Secure necessary emergency medical (physical/mental health) care for the above-named enrollee and transport to such services, as needed.	
Assignment of Benefits If applicable, I hereby assign payment directly to Children's Community Mental Health Services and Wraparound Milwaukee Program for the benefits otherwise payable to me by any third party, including: transitional benefits, but not to exceed the current cost of mental health treatment services.	

EXPIRATION OF AUTHORIZATION / WITHDRAWAL OF AUTHORIZATION

If not specified below, I understand that this Authorization to Release/Exchange Information EXPIRES 12 MONTHS from the date it is signed. I understand that I may cancel this authorization at any time (see back of sheet for instructions). This cancellation does not include any information that has been shared between the time I gave my consent to share information and the time that the consent was canceled.

This authorization expires on the ______________ day of ____________________________, 20______.

REDISCLOSURE NOTICE: I understand that information used or disclosed based on this authorization may be subject to re-disclosure and no longer protected by Federal privacy standards.

____________________________	__________	______________________________	__________
Parent/Legal Guardian's signature	Date	Enrollee's Signature (age 14 and older must sign)	Date
____________________________	_________		
Witness signature	Date		

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
1220 W Vliet Street, 3rd Floor
Milwaukee, WI 53205
wrapqa@milwaukeecountywi.gov

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)

မြန်မာစာ **(Myanmar) (Burmese)** - အထူးသတိပြုရန် - အကယ်၍ မြန်မာဘာသာစကားကို သင်ပြောဆိုနိုင်ပါက ဘာသာစကားဆိုင်ရာ ဝန်ဆောင်မှုများကို အခမဲ့ သင် ရရှိနိုင်ပါသည်။ သင့် စောင့်ရှောက်မှု ဆက်စပ်ဆောင်ရွက်ပေးသူ ထံသို့ တိုက်ရိုက် ဖုန်းခေါ်ဆိုပါ သို့မဟုတ်လျှင်လည်း 1-833-912-2468 (TTY: 711) သို့ ခေါ်ဆိုပါ။

Chinese注意：如果**您使用中文，那么您可以免**费获得语言协助服务。请直接联系您的护理协调员，或致电 1-833-912-2468 (TTY: 711)。