West Central Wisconsin Behavioral Health

Intoxicated Driver Program Client Responsibility Agreement

I AGREE if I miss my scheduled appointment and do not notify my assessor of my need to reschedule at least 24 hours in advance, I forfeit my assessment cost. I must then pay the fee in full at the time I reschedule another assessment. A missed appointment is considered any time after my scheduled appointment time.

I AGREE that I will be present in the state of WI for my assessment. If I am not in the state of WI, I forfeit my assessment cost. I then must pay the fee in full at the time I reschedule another assessment.

I AGREE at the time of my assessment I may be subject to an alcohol and/or drug screening. This may include a breathalyzer or urine sample. I understand that if I am under the influence of any substance, I may not complete my assessment and will need to reschedule at a fee of $50. If I do not reschedule within six months, I will forfeit the assessment fee and will need to pay it again.

I AGREE if I make payment arrangements for the assessment, an additional $50 fee will be assessed to my account. My assessment will not be scheduled until my account balance is $0. (Please review and sign additional form for payment arrangements).

I AGREE if my assessment is paid in full, I will schedule my assessment within one (1) year; otherwise, I will forfeit the fee and will have to pay the fee again.

I AGREE if I need an extension of time, an amendment of provider or treatment agency, I must notify the assessor prior to the original plan termination date. I will also be required to pay an additional fee of $50.

I AGREE if I need a follow up appointment including a transfer of residence, a fee of $50 will be assessed for each follow up appointment. This includes if my address is not updated at the time of the assessment.

I AGREE if I have received an OWI in another state (Minnesota, Iowa, Illinois, etc.) there will be additional assessment fees. Please notify us now to inquire about these fees.

I AGREE if I am placed in non-compliance and there is not reasonable time for me to complete my original Driver Safety Plan, I will need to be re-assessed. I will need to follow the same procedure to schedule this assessment, including paying the full fee.

I AGREE if I am placed into non-compliance for any other reason (failure to pay treatment fees, missed treatment appointments, etc.) I will be required to pay a fee of $50 to complete, communicate and file your paperwork with the Wisconsin DOT if the plan has not expired.

I AGREE if it is found out during my assessment that I am not a Pierce County resident, I will not receive a refund and will be required to complete my assessment in the county I reside.

I, _____ acknowledge that I have read and understand the above responsibilities.

(Please Print)

_____ _____

Signature **Date**

****To obtain an appointment, please complete all the forms, a payment of $280 in the form of cash, money order, or credit/debit card. Along with these forms and payment, your police report/criminal complaint is needed to obtain an appointment****

West Central Wisconsin Behavioral Health

Intoxicated Driver Program Registration

Date: _____ Social Security Number: _____-_____-_____

Legal Full Name: _____
(Last) (First) (MI)

Other last names held: _____

Client Address: _____
(Street – Including PO Boxes) (City) (State) (Zip)

Home Phone: _____ Cell Phone: _____

Gender: _____ Date of Birth: _____ Ethnicity: _____

Marital Status (Circle one): Single Married Divorced Widowed Separated

Spouse Name: _____

Your Occupation: _____ Length of time on job:_____

EMERGENY CONTACT & RELATIONSHIP TO CLIENT (OTHER THAN HOME)

1. _____ _____ _____
(Name) (Relationship) (Phone)

This is to acknowledge that I do live in Pierce County.
I understand that if the assessor is unable to do my assessment due to my address being outside the County of Pierce, I will forfeit the assessment fee of $280 as a paperwork and service fee and will need to complete the assessment in the county I legally reside.

_____
Signature Date

West Central Wisconsin Behavioral Health

CIRCLE THE APPROPRIATE NUMBER OR FILL IN THE BLANK AREAS.

EDUCATION AT TIME OF ADMISSION:

1. Highest Grade Completed: _____
2. High School Diploma or GED
3. Some College or Vocational/Technical School:
   Associate Degree or Voc/ Technical Degree
4. Bachelor's Degree
5. Advanced Degree (Master's; Ph.D.)

EMPLOYMENT STATUS:

1. Employed Full Time – 35 hours or more a week
2. Employed Part Time – 35 hours or less a week
3. Unemployed – looking for work in the past 30 days, includes registering for employment and on lay-off from job
4. Unemployed – not looking for work in the past 30 days
5. Not in Labor Force – other (homemaker, student, disabled, retired, institution inmate, incarcerated, others)

EMPLOYMENT HISTORY:

1. Steadily employed – worked 11-12 months
2. Minor periods of unemployment – worked 9-10 months
3. Moderate periods of unemployment – worked 6-8 months
4. Major periods of unemployment – worked 5 months or less

AGE OF FIRST DRUG USE OR ALOHOL INTOXICATION: _____

Primary Substance used? _____

Route of admission (Circle one): Oral Smoking Inhalant Injections Other

Frequency in the last month (Circle one): No Use Daily

1-3 times per month 3-6 times per week 1-2 times per week

Other Drug/medication use (this includes prescriptions from your doctor)?
_____

Number of self-help groups (AA, NA, etc.) attended in the last 30 days? _____

WEST CENTRAL WISCONSIN BEHAVIORAL HEALTH

TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Messages regarding my care may be left on the phone number below: **Yes** ☐ **No** ☐

_____

1. **Permission to Use and Disclose Your Health Information.**
   Authorize us to use and/or disclose your health information for *treatment, payment or health* care operations. You have the right not to sign this acknowledgement. Refusing to sign this acknowledgement may give us the right to refuse to treat you.
2. **Your Rights with Respect to This Acknowledgement.**
   a. **Right to Review Notice of Privacy Practice.** We have provided you a copy of our Notice of Privacy Practices. You have the right to review this Notice before signing this acknowledgement. You may obtain a copy of our Notice, including any revisions we have made by contacting ***our office***.
   b. **Right to Request Restrictions on Use/Disclosure.** You have the right to request that we restrict how we use and/or disclose your health information for providing treatment, obtaining payment for our services, and/or conducting health care operations. All requests must be made in writing. We are not required to agree to any restriction you may request. If we agree to a restriction you have requested, we must restrict our use and/or disclosure of your health information in the manner described in your request. To obtain a restriction request form, please contact ***our office***.
   c. **Right to Revoke Acknowledgement.** You have the right to revoke this acknowledgement at any time. Your revocation of this acknowledgement must be in writing. Note that your revocation of this acknowledgement will not be effective for disclosers we have already made in reliance on your prior acknowledgement. We have the right to refuse to provide further treatment if you revoke this acknowledgement. To obtain a revocation form, please contact ***our office***.
   d. **Right to Receive a Copy of This Acknowledgement Form.** You have the right to receive a copy of this acknowledgement form after you sign it.
3. **Effective Period.**
   This acknowledgement is effective on the date of signing and shall remain in effect indefinitely, unless you revoke it earlier in writing.

I hereby authorize West Central Wisconsin Behavioral Health to use and/or disclose my health information for treatment, payment or health care operations.

_____

Client Signature Date

West Central Wisconsin Behavioral Health

Consent for Telehealth Services

- I have been asked to receive mental health services through telehealth—telehealth refers to the use of having services provided through interactive audio/video and/or telephone equipment rather than having the provider be physically present in the room.
- I understand that my participation in telehealth is voluntary and that I have the right to refuse participation in telehealth services at any time.
- I understand that information about my telehealth appointments will be documented within my clinical record through West Central Wisconsin Behavioral Health. I understand that I have the right to request my records, inspect any information transmitted during a telehealth appointment, and to receive copies of this information for a reasonable fee.
- Confidentiality still applies to telehealth services and the appointments will not be recorded without the permission from the other person(s).
- I understand that I will be present in the state of WI for appointments unless otherwise discussed with the provider or the appointment may be rescheduled.
- It is important to be in a quiet, private location that is free from distractions (i.e., other people, cellphones, televisions) during the appointment.
- It is important to use a secure internet connection rather than public/free Wi-Fi connections.
- It is important to be on time for your appointment and attend regularly. If you need to cancel or reschedule the appointment, please notify the behavioral health clinic in advance by telephone.
- West Central Wisconsin Behavioral Health staff may determine that due to certain circumstances, telehealth is no longer an appropriate option. If this becomes applicable, staff will try to assist you in connecting with in-person resources.
- There are potential risks and benefits of telehealth services:
    - Potential benefits:
        - Reduced travel for myself and the provider
        - Quicker access
        - This may be the only service option available during COVID-19 pandemic situation
    - Potential risks:
        - Audio/video connection could fail or be disrupted during appointment
        - Connectivity issues may result in an unclear picture and/or sound
        - There is a very small chance someone could be utilizing electronic tampering to access the appointment
- We will need a phone number you can be reached at in the event of a technical problem.

Phone number: _____

- We need a safety plan that includes at least one emergency contact and the closest emergency room (ER) to your location, in the event of an emergency/crisis situation.

Emergency contact: _____ Closest ER: _____

Signature: _____ Date: _____

West Central Wisconsin Behavioral Health

Intoxicated Driver Program Treatment Resources List

This list is available and commonly used treatment and/or education providers within our area. **You will need to choose one of the education/treatment providers listed below or an agency within your insurance network at the time of your assessment.** If you are unable to decide at the time of your assessment, you will need to schedule a follow up at a cost of $50. If you are choosing your own provider not on this list, please call and ensure the agency has a DHS 75 certification in order to qualify. You are responsible for full payment of treatment or education.

Group Dynamics / Multiple Offender: Education Course

- Eau Claire, Menomonie, and River Falls Area – Chippewa Valley Technical College
  - Group Dynamics
  - Multiple Offender (only offered in Eau Claire)
- New Richmond Area - Northwood Technical College
  - Group Dynamics
  - Multiple Offender
- Community Counseling Services, Chippewa Falls (Must be pre-approved for alternative education to finalize the driver safety plan)
  - Group Dynamics
  - Multiple Offender

Outpatient Treatment Agencies:

- Arbor Place – River Falls and Menomonie
- Common Ground – Red Wing, MN
- Faith Family Recovery Center – Hastings, MN
- Gateway Counseling – Eau Claire 8–16-week groups
- Hudson Medical Center, Programs for Change – Hudson
- L. E. Phillips – Chippewa Falls
- Pierce County Department of Health and Human Services - Ellsworth

The choice of provider agency must be based on the recommendation contained in the driver safety plan. I understand these resources have been listed to assist me in selecting a treatment provider. I understand that I may refuse to participate in a program containing religious/spiritual elements and that I will inform the assessor of my objection. My treatment choice was made voluntarily with full knowledge of program content as related to my civil rights. I voluntarily consent to participate in the program I have chosen. By signing this form, I agree I have been provided the above choices.

Chosen provider will be reflected on the driver safety plan

It is your responsibility to contact your counselor from the agency that was chosen and have them send the OWI assessor an update on your progress.

_____

Signature Date