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|  WRAPAROUND MILWAUKEE POLICY & PROCEDURE | Date Issued: 9/1/98 | Date Revised: 12/3/07 | Section: MOBILE CRISIS | Policy No: 027 | Pages: 1 of 1 (2 Attachments) |
| | <input type="checkbox"/> Wraparound <input type="checkbox"/> Wraparound/REACH <input type="checkbox"/> FISS | Effective Date: 1/1/08 | Subject: MOBILE URGENT TREATMENT TEAM (MUTT) – CONSENT FOR TREATMENT | | |

I. POLICY

It is the policy of Wraparound Milwaukee to serve the specialized population of severely emotionally disturbed individuals who are in mental health crisis and at imminent risk of out-of-home placement, and to reduce the need for institutional placement of severely emotionally disturbed individuals who are in crisis and at imminent risk of out-of-home placement.

The Mobile Urgent Treatment Team serves all individuals and families of Milwaukee County, with emphasis on individuals with disabilities and complex needs. The Team provides information and referral, crisis services, and short-term case management services. The service is voluntary, culturally competent and family centered.

II. PROCEDURE

The Mobile Urgent Treatment Team operates 7 days a week, 24 hours a day and **can be reached at (414) 257-7621**.

The Team receives phone calls from anyone in the community, but must have guardian approval before providing any services other than brief crisis assessment, when a child presents as dangerous to self or others.

The Wraparound Milwaukee Enrollment Packet will include the following forms:

- ◆ M.U.T.T. - CONSENT FOR TREATMENT (*see Attachment 1*).
- ◆ WM – M.U.T.T. – AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION (*see Attachment 2*).

When/if completed by the parent/guardian at the time of enrollment, the above forms should be sent to:

WRAPAROUND MILWAUKEE
9201 Watertown Plank Road
Milwaukee, WI 53226
Attn: MUTT

or Faxed to MUTT at (414) 257-7575

The Team triages referrals and decides to intervene with services based on the clinical needs of the individual and family.

Reviewed & Approved by: _____



Bruce Kamradt, Director

WRAPAROUND MILWAUKEE

**MOBILE URGENT TREATMENT TEAM (MUTT)
CONSENT FOR TREATMENT**

I, _____, as Parent/Guardian of

(Child's name) _____ DOB _____

authorize the Mobile Urgent Treatment Team and/or its contracted Crisis Service providers to:

- _____ a. Provide Crisis Intervention for the above named child.
- _____ b. Voluntarily transport the above named client.
- _____ c. Secure necessary emergency medical (physical/mental health) care for the above named client and transport to such services.

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 the Mobile Urgent Treatment Team 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 youth for all treatment services provided during the next three years. By law, this information can also be shared with the State of Wisconsin Department of Health and Family Services.

ASSIGNMENT OF BENEFITS

I hereby assign payment directly to 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 the Mobile Urgent Treatment Team program.

NOTICE OF PRIVACY PRACTICES

I have received and understand the Mobile Urgent Treatment Team 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 should sign)

Signature of Witness _____ Date Signed _____

WRAPAROUND MILWAUKEE
MOBILE URGENT TREATMENT TEAM
AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

PURPOSE OF DISCLOSURE / EXCHANGE OF INFORMATION:

Release of Mental Health and AODA (Alcohol and Other Drug Addiction) and Physical Health information that will be used to plan and provide for the care, treatment and service for:

_____ (Youth's Name) _____ (Date of Birth)

I authorize the Mobile Urgent Treatment Team and/or it's contracted Crisis Service providers to release / exchange information that may include diagnosis, prognosis, and/or mental health, physical health (including HIV) and Alcohol and other Drug Addiction (AODA) related information.

AUTHORIZATION FOR RELEASE OF INFORMATION:

Additionally, information as indicated below may be shared with the following:

SHARED DOCUMENTS (Check Those that Apply)

| Emergency Planning | Referral for Services | Other * (See Below) | |
|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Milwaukee Public Schools/other school_____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Milwaukee County Children's Court |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bureau of Milwaukee Child Welfare |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Milwaukee County Behavioral Health Division/Programs |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Other _____ Agency/Individual |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Other _____ Agency/Individual |

*Other Document/s _____

EXPIRATION OF AUTHORIZATION / WITHDRAWAL OF AUTHORIZATION:

If not specified below, I understand that **this Authorization for Release of Information EXPIRES 12 MONTHS from the date it was signed.** I understand that **I may cancel this authorization at any time** (see back of sheet for instructions). This 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_____.

REDISCLASURE 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 or Legal Guardian Signature Date

Youth Signature (Youth age 14 and older should sign) Date

Witness Signature Date

CLIENT RIGHTS RELATED TO AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Receive Copy of This Authorization - I understand that if I sign this authorization, I will be provided with a copy of this authorization.

Right to Refuse to Sign This Authorization - I understand that I am under no obligation to sign this form and that Wraparound Milwaukee may not condition treatment, payment, enrollment in a program on my decision to sign this authorization except regarding: program enrollment or eligibility.

Failure to Sign - I understand that failure to sign this authorization may severely limit the treatment / service options available for my child or family.

Right to Withdraw This Authorization - I understand that I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to Pamela Erdman, Wraparound Milwaukee Quality Assurance Department. (The statement must be dated and signed). I am aware that my withdrawal will not be effective until received by Wraparound Milwaukee and will not be effective regarding the uses and/or disclosures of my health information that Wraparound Milwaukee has made prior to receipt of my withdrawal statement

Right to Inspect or Copy the Health Information to Be Used or Disclosed - I understand that I have the right to inspect or copy (may be provided at a reasonable fee) the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting Pamela Erdman in the Wraparound Milwaukee Quality Assurance Department.

HIV Test Results - I understand my child's HIV test results may be released without authorization to persons/organizations that have access under State law and a list of those persons/organizations is available upon request.

Submit your written requests for withdrawal to:

Ms. Pamela Erdman, Wraparound Milwaukee Quality Assurance Director
Wraparound Milwaukee Administrative Offices
9201 Watertown Plank Road
Milwaukee, WI 53226 Phone: (414) 257-7608