Central Wisconsin Health Partnership

Comprehensive Community Services

Application and Admission Agreement

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| Application Date: | | |  | | | | | | |  | | | | | | | | | | | | | | | | | | | | |
| Name |  | | | | | | | | | | DOB | | |  | | | | | | | | | Gender | | | |  | | | |
| SSN |  | | | | | | | | | | Medicaid # | | | | | | |  | | | | | Other Insurance | | | |  | | | |
| Address |  | | | | | | | | | | City | |  | | | | | | | | | | Zip | | | |  | | | |
| Phone |  | | | | | | | | | | Other Phone | | | | | | | |  | | | | Number of Children | | | | |  | | |
|  |  | | | | | | | | | |  | | | | | | | | |  | | |  | | | |  | | | |
| Veteran | Y or N | | | | Hispanic | Y or N | | | Ethnicity | | | | | | White  Asian  Black/African American  Native Hawaiian/Pacific Islander American Indian/Alaskan Native | | | | | | | | | | | | | | | |
| Referral Source | Self DHS  Medical School Other | | | | | | | | | | | | | | | | Relationship Status: | | | | | | |  | | | | | | |
| School Attending | | | |  | | | | | | | | | | | | | Grade | | | |  | | | | | | | | | |
| Parent or Guardian | |  | | | | | | | | | | | | | | | Phone | | | |  | | | | | | | | |  |
| Address *(if different)* | |  | | | | | | | | | | | | | | | | | City | |  | | | | | | Zip | |  | |
|  | |  | | | | | | | | | |  | | | |  | | | | | | | | |  |  | | | | |
| *Please list others living in the home (children, siblings, grandparents, other adults, etc.):* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| *Name* | | | | | | | | *Relationship* | | | | | | | | | | | | | | | | | | | | | | |
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| *Possible Team Members (natural supports, friends, neighbors, teachers, etc.):* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name | | | | | | | Relationship | | | | | | | | | Phone Number | | | | | | Address *(if different from Applicant)* | | | | | | | | |
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| *List other Service Providers (include residential provider, family physician, social workers, therapists, etc.):* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name | | | | | | | Profession or Relationship | | | | | | | | | *Address/Phone* | | | | | | | | | | | | | | |
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| **Comprehensive Community Services**  The Comprehensive Community Services (CCS) Program is a community-based psychosocial rehabilitation Service that provides or arranges for psychosocial rehabilitation services for eligible adult or child consumers.  *Psychosocial rehabilitation services are medical and remedial services and supportive activities that assist the consumer to achieve his or her highest possible level of independent functioning, stability and independence and to facilitate recovery.*  Services are provided during the agency operational hours (Monday through Friday from 8:00 a.m. to 4:30 p.m.), but may be provided after-hours by arrangement when a need is determined.  Crisis Intervention Services are available during and after-hours. Crisis services may be accessed by calling the Juneau County Human services at 608-847-2400 during day time hours and calling Hess Memorial Hospital at 608-847-6161 afterhours and requesting them.  CCS Staff Member Titles and Responsibilities:   * *Service Facilitator* has overall responsibility for all the activities related to coordinating your Recovery Plan, such as pulling together meetings of your Recovery Team, ensuring that your voice is heard and opinions are shared with all members of your Recovery Team * *Mental Health Professional* reviews and attests to your need for psychosocial rehabilitation services to address your desired recovery goals. This individual participates in the assessment process and authorizes the services on the Service Plan. * *Substance Abuse Professional* will conduct an assessment of your substance use, strengths, and treatment needs and establish any substance use diagnosis. This individual also signs off on your Service Plan.   **Consumer Rights**  All rights outline in the *Your Rights and the Grievance Procedure* brochure apply to Comprehensive Community Services. In addition, Consumers of the CCS have the right to:   1. Choice in the selection of recovery team members, services, and service providers. 2. The right to specific, complete and accurate information about proposed services. 3. The fair hearing process under s. HFS 104.01 (5) for Medical Assistance consumers. For all other consumers the right to request a review of a CCS determination by the Department of Health and Family Services.   **Acknowledgement**  I acknowledge that I have read this agreement and understand the nature and purpose of the Comprehensive Community Services program.  I have received a copy of *Your Rights and the Grievance Procedure,* and it has been explained to me.  I have been provided with information on the cost of services as well as my financial responsibility for the services I receive.  **I HEREBY CONSET TO COMPREHENSIVE COMMUNITY SERVICES**   * If the consumer is a competent adult, then only his or her signature is required. * If the consumer is 14 years old or older but not yet eighteen, then BOTH the consumer and a parent or guardian must sign. * If the consumer is under the age of 14 years old, then only the parent or guardian must sign. * If the consumer has been adjudged to be incompetent the appointed guardian must sign. |
| Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature of Parent or  Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |