

## REQUEST FOR MEDIATION SERVICES

If you are experiencing difficulties with physical placement (visitation) of your minor child(ren), Wisconsin Statutes provide that you first attempt to mediate your differences prior to formal Court action.

The purpose of mediation is to assist parents in learning to establish a solution to their placement issues and avoid the emotional and financial burdens Court actions may entail. The focus of mediation is to reach an agreement or plan which will be in the best interest of your child(ren). If you are unable to reach an agreement or fail to follow the visitation schedule you agreed to in mediation, you may then be advised to file a motion with the Court for judicial determination of your disputed issues.

The forms necessary to start the mediation process are attached. Please read through this document carefully and completely before you proceed. All appointments, payments, and questions concerning mediation are handled by the Calumet County Department of Health and Human Services, 206 Court Street, Chilton, WI 53014.

**FEES:** The fee for mediation in Calumet County is \$400.00. One-half of the fee (\$200.00) must be prepaid to the Department of Health and Human Services by each party before an appointment for mediation is scheduled. Payments may be delivered or mailed to the department along with your completed *Request for Mediation Services, Mediation Questionnaire, Face Sheet and Notice to Client* forms. If you believe you cannot afford to pay this fee you may elect to meet with a Health and Human Services' billing clerk to determine your ability to pay.

Your first appointment will be scheduled as a two-hour block of time which includes orientation. If you choose not to mediate after the orientation session, a full refund may be granted. If you choose to continue with mediation after the review, you will be asked to sign an Agreement to Mediation form and continue the mediation process.

**If you desire to pursue mediation services you must do the following:**

1. Complete and return the attached *Request for Mediation Services, Mediation Questionnaire, Face Sheet and Notice to Client* forms to the Department of Health and Human Services.
2. Pay your mediation fee at the Department of Health and Human Services. Please make check or money orders payable to **Calumet County Department of Health and Human Services**.

The Department of Health and Human Services will send your request for mediation services to the Clerk of Courts for proper processing. Upon receipt of the proper court orders, the Department of Health and Human Services will then contact you to schedule your first mediation appointment.

**REQUEST FOR MEDIATION SERVICES IN CALUMET COUNTY**  
 (Please complete this form as thoroughly as possible to avoid delays in processing.)

CASE #: \_\_\_\_\_

	Petitioner	Respondent
<b>Name</b>		
<b>Address</b>		
<b>Date of Birth</b>		
<b>Telephone</b>		
<b>Attorney: Name</b>		
<b>Address</b>		
<b>Phone #</b>		

**CHILDREN**

Name	Date of Birth	School/Grade

The minor child/ren are currently in the legal custody of:

What is the current court ordered visitation or access to the child/ren?

Please explain your current concerns:

Please describe what you feel might be a solution to your concerns:

I certify that the above information provided is true to the best of my knowledge.

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

### **MEDIATION QUESTIONNAIRE**

*Please do not let the other party see your answers to this questionnaire.*

1. Do you have any concerns about your children's safety, emotional or physical, when they are with the other parent?
  - a. If yes, was \_\_\_\_\_ child protective services or \_\_\_\_\_ the police involved?
  - b. When and what was the outcome?
  
2. Has Calumet County Department of Human Services ever been involved with the family? If so, when?
  - a. What was the outcome?
  
3. Has the Court appointed a separate Child's Representative or GAL (Guardian ad Litem)?
  
4. Have you ever feared that you would not have access to your children? Why?
  
5. Do you currently or have you ever had any problems with alcohol or drugs? Have you ever received treatment for drugs or alcohol?
  
6. Do you believe that parents or family members have problems with alcohol or drugs? Have they been in treatment?
  
7. Have you or any members of your family ever been convicted of driving while under the influence of alcohol or drugs?
  
8. Have there ever been any physical, verbal or psychological abuse, or threats to personal safety between you and the other party? Please describe.
  
9. Are there now, or have there ever been, any Orders of Protection or any Restraining Orders? (If yes, please include the Restraining Order with this form.)
  
10. Do you have any concerns about your physical or emotional safety with the other parent?
  
11. Do you have any concerns about your safety when coming to or leaving the Department of Health and Human Services for appointments?
  
12. Are you afraid to meet with the other party and the mediator?

13. Do you have any safety concerns should you disagree with the other person in mediation?

14. Do you feel ready to work on a parenting plan? If no, why?

15. Were you afraid to answer these questions. If yes, why?

16. Did someone assist you in completing this form? If yes, why? Who?

\_\_\_\_\_

Name

\_\_\_\_\_

Date

**CALUMET COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES  
FACE SHEET- ADULT**

Date: \_\_\_\_\_

Legal Name: \_\_\_\_\_  
(First, Middle, Last)

Previous Last Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

County: \_\_\_\_\_

Directions to your home: \_\_\_\_\_

\_\_\_\_\_

Telephone Number: Home: \_\_\_\_\_

Work: \_\_\_\_\_

May we contact you at work?  Yes  No

Employer: \_\_\_\_\_

Job Title: \_\_\_\_\_

Name of Spouse or Partner: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_

Address of Spouse, if different from yours: \_\_\_\_\_

\_\_\_\_\_

Other people in your household:

Name

Date of Birth

Relationship to You

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Who referred you to this Department? \_\_\_\_\_

Reason you are requesting service? \_\_\_\_\_

Male  Female

Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_

Social Security # \_\_\_\_\_

Ethnic Group:

- African American
- American Indian (Tribe \_\_\_\_\_)
- Asian or Pacific Islander
- Hispanic
- White

Education Level: \_\_\_\_\_

Veteran?  Yes  No

Marital Status:  Single  Married

Widowed  Divorced  Separated

Legally Separated  Never Married

Telephone number of spouse if different from

Yours: \_\_\_\_\_

Have you ever received services from our Department before? (either from the former Unified Services Center or the Calumet County Department of Human Services) \_\_\_\_\_

Have any others members of your family ever received services from our Department? (either from the former Unified Services Center or the Calumet County Department of Human Services) \_\_\_\_\_

Family member who received services: \_\_\_\_\_

Approximately when: \_

Are you or anyone in your household currently receiving:

- |                                   |                          |     |                          |                     |
|-----------------------------------|--------------------------|-----|--------------------------|---------------------|
| Social Security                   | <input type="checkbox"/> | You | <input type="checkbox"/> | Other Family Member |
| Supplemental Security Income/ SSI | <input type="checkbox"/> | You | <input type="checkbox"/> | Other Family Member |
| Food Stamps                       | <input type="checkbox"/> | You | <input type="checkbox"/> | Other Family Member |
| AFDC                              | <input type="checkbox"/> | You | <input type="checkbox"/> | Other Family Member |
| General Relief                    | <input type="checkbox"/> | You | <input type="checkbox"/> | Other Family Member |

Are you currently covered by Medicare?  Yes  No Number: \_\_\_\_\_

Are you currently covered by Medical Assistance?  Yes  No Number: \_\_\_\_\_

Are you currently covered by Health Insurance?  Yes  No Number: \_\_\_\_\_

In case of an emergency, please give us the name of your physician and what city he/ she is located in:

\_\_\_\_\_

In case of an emergency, please give us the name and phone number of someone to contact:

Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

**NOTICE TO CLIENTS**  
**CONTACT BY CALUMET COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES**

State and Federal confidentiality laws do not allow Calumet County Department of Health and Human Services to disclose that individuals receive services from the Department except in certain emergency situations as required by law or with the specific consent of the client. Therefore, when attempting to contact you to schedule or change appointments or to discuss any service issues, Calumet County Department of Health and Human Services will not leave messages at your home or workplace that might identify you as a client of the Department unless you provide specific authorization for such messages.

If it is agreeable for messages to be left at your home or workplace, please complete the form below. Please inform us of any change in your home or work situation or in this authorization.

I, \_\_\_\_\_, do hereby authorize Calumet County Department of Health and Human Services to contact me in the following manner:

1. At my home phone number of \_\_\_\_\_  
May we leave a message on the voice mail/answering machine for this number?  No  Yes  
May we leave a message with anyone?  No  Yes If so, who? \_\_\_\_\_  
E-mail address: \_\_\_\_\_  
The best time to contact me is: \_\_\_\_\_  
The best time for an appointment is: \_\_\_\_\_  
The following instructions are to be followed: \_\_\_\_\_
2. At my place of employment during the hours: \_\_\_\_\_  
May we leave a message on the voice mail/answering machine for this number?  No  Yes  
May we leave a message with anyone?  No  Yes If so, who? \_\_\_\_\_  
E-mail address: \_\_\_\_\_  
The best time to contact me is: \_\_\_\_\_  
The best time for an appointment is: \_\_\_\_\_  
The following instructions are to be followed: \_\_\_\_\_
3. Other: \_\_\_\_\_  
Emergency Contact person: \_\_\_\_\_  
Phone: \_\_\_\_\_

**I authorize Calumet County Department of Health and Human Services (DHHS) to contact my insurance provider and release information regarding the client to determine the benefits payable for provided services and to obtain any necessary prior authorization. I furthermore request payment of authorized benefits be made directly to Calumet County DHHS. By signing this form, I acknowledge that I have received information regarding potential fees and been provided with information to discuss fee reduction and waiver options with the billing department.**

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Client's Name

\_\_\_\_\_  
Signature of Person Authorized to Sign for Client

\_\_\_\_\_  
Relationship to Client

## **AGREEMENT ON THE USE OF ELECTRONIC MAIL AND TEXT MESSAGING FOR CONSUMER COMMUNICATIONS**

The use of e-mail or text messaging may be used to enhance communications between Consumer and the Calumet County Department of Health and Human Services ("Provider").

The following policies and procedures are established to communicate the importance of the confidential Provider-Consumer relationship. This may include protected personal and health information. The term provider includes any employee of Calumet County DHHS.

In signing this agreement the Consumer understands the information provided. This agreement can be terminated at any time.

1. Use of E-mail or Text Messaging Communications. Consumer agrees and understands that Consumer may use e-mail or texting to communicate with Provider regarding certain administrative matters arising from services rendered to Consumer. Consumer shall not use e-mail or texting to communicate with Provider and shall use other means of communication (e.g., telephone, personal visit) for:

- (a) emergencies or other time-sensitive issues;
- (b) highly confidential and/or personal information.

The Provider shall make a reasonable attempt to return all e-mail or text messages received within two (2) business days or to notify the Consumer that the Provider is unavailable. Notwithstanding the foregoing, if Consumer does not receive a response by the close of business on the second business day following Consumer's e-mail or text message, Consumer agrees to use other means of communication to contact the Provider. Similarly, Consumer agrees that Providers may use their reasonable professional judgment to determine whether any response by e-mail or text message is appropriate or practical, and request that Consumer either speak with the Provider by telephone or make an appointment for an in-person visit.

2. Composing E-mail or Text Messages. When composing e-mail or text messages to Providers, Consumer shall:

- (a) Write concisely.
- (b) For emails only: Include Consumer's first and last initials only in the subject line, and a brief description of the nature of the request.
- (c) Keep copies of e-mail or text messages sent and received.
- (d) When requested by Provider, send a reply to the Provider to acknowledge receipt and review of e-mail or text message from Provider.

3. Access to Consumer's E-mail or Text Communications. By entering into this Agreement, Consumer understands and acknowledges that it may be necessary for Providers other than the Provider to whom the message is addressed to access e-mail or text messages sent by Consumer to the Provider, in order to help Provider organize and respond to e-mail or text messages received from Consumer, to cover for Provider if Provider is not available, and, in some cases, to assist in generating a response. Consumer hereby authorizes any Provider of the Practice to access Consumer e-mail or text messages. Further, the Provider may use non-clinical personnel to organize and respond to e-mail or text messages regarding billing or other administrative matters. Consumer hereby authorizes personnel of the Provider's organization to access e-mail or text messages sent to Providers which include inquiries related to administrative matters.

4. No Liability. Consumer agrees that e-mail and/or text communications with the Provider or any other provider is offered as a convenience to Consumer, and Consumer shall not hold the Provider responsible for any expense, loss, or damage caused by, or resulting from: (i) a delay in the Provider's response to Consumer, or any damage to Consumer resulting from such delay, due to technical failures, including, but not limited to, technical failures attributable to the Provider's internet service provider, cellular service provider, power outages, failure of the Calumet County electronic messaging software, failure by Provider or Consumer to properly address e-mail or text messages, failure of the Provider's computers or computer network, or faulty telephone or cable data transmission; (ii) any interception of Consumer's or Provider's e-mail or text communications by a third party; or (iii) Consumer's failure to comply with the guidelines regarding use of e-mail or text communications set forth in Section 1, above.

5. Confidentiality. Provider shall exercise reasonable efforts to ensure the confidentiality of Consumer e-mail or text communications, however, Consumer understands that e-mail and/or text communications to the Provider's organization are not secure, and there is therefore some possibility that the confidentiality of such communications will be breached by a third party. **Communication regarding highly confidential medical and/or personal matters should therefore be reserved for other forms of communication (e.g., telephone, personal visit)**. If Consumer accesses Provider through an employer's e-mail system or cellular text messaging service, Consumer should be aware that the Provider's employer has the right to review any e-mail or text message communications transmitted through the Provider's e-mail system.

6. Archiving. The Provider may keep copies of e-mail and text messages that Consumer sends to Providers and may include such messages in Consumer's medical record.

7. Termination. This Agreement may be terminated by the Provider if the Provider determines that the Consumer has failed to comply with its provisions. Upon Termination of this Agreement, the Provider will no longer respond to the Consumer's e-mail and/or text communications in the regular course of providing services to the Consumer. However, the Provider shall reserve the right to respond to any e-mail or text communications from the Consumer, if Provider determines that such a response is appropriate or practical.

8. Miscellaneous. This Agreement shall constitute the entire understanding between the parties with respect to e-mail and text communications, and shall supersede any prior understanding or agreement between the parties, whether oral or written.

A copy of this policy may be provided upon request.

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Client's Name

\_\_\_\_\_  
Signature of Person Authorized to Sign for Client

\_\_\_\_\_  
Relationship to Client

## TELEHEALTH INFORMED CONSENT FORM

I \_\_\_\_\_, consent to engaging in telehealth with Calumet County Health & Human Services. I understand that telehealth will occur primarily through interactive audio, video, telephone and/or other audio/video communications.

I understand I have the following rights with respect to telehealth:

1. I have the right to withhold or remove consent at any time without affecting my right to future services.
2. The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information released by me during the course of my sessions is generally confidential. There are both mandatory and permissive exceptions to confidentiality including, but not limited to, reporting child and vulnerable adult abuse, expressed imminent harm to oneself or others, or as a part of legal proceedings where information is requested by a court of law. I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to other entities shall not occur without my written consent.
3. I understand that there are risks and consequences from telehealth including, but not limited to, the possibility despite reasonable effort on the part of the Calumet County Health & Human Services that: the transmission of my personal information could be disrupted or distorted by technical failures and/or the transmission of my personal information could be interrupted by unauthorized persons.
4. I understand that I may benefit from telehealth services, but the results cannot be guaranteed or assured. I understand that the use of Skype, FaceTime, GoToMeeting and Google audio/video systems are not 100% secure and may have issues with Wi-Fi connectivity. All attempts to keep information confidential while using these systems will be made, but a guarantee of 100% confidentiality cannot be made with inherent issues with these communication systems. Signing this form shows an awareness of these issues and a decision by this consumer to use these systems for telehealth services. I will not hold Calumet County Health & Human Services or its staff liable for gathering or use of client information by these service providers.
5. By signing this document, I agree that certain situations, including emergencies and crises, are inappropriate for audio/video/computer-based services. If I am in crisis or in an emergency, I should immediately call 911 or go to the nearest hospital or crisis facility.

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Client's Name

\_\_\_\_\_  
Signature of Person Authorized to Sign for Client

\_\_\_\_\_  
Relationship to Client