KEWAUNEE COUNTY DEPARTMENT OF HUMAN SERVICES
810 Lincoln Street
Kewaunee, WI 54216
Phone: (920) 388-7030 Fax: (920) 388-7124

There are two parts to the Intoxicated Driver Program: an alcohol and other drug abuse (AODA) assessment and a driver safety plan.

AODA ASSESSMENT

Anyone convicted of an operating while intoxicated (OWI) related offense is required to contact the human services department for their county of residence within 72 hours of conviction. Failure to contact the human services department within 72 hours will result in the suspension of your driver's license, including an occupational license, until you are in compliance.

The designated agency for residents of Kewaunee County is:

Kewaunee County Department of Human Services
810 Lincoln Street
Kewaunee, WI 54216
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The assessment evaluates an individual's alcohol and/or other drug use habits. Assessors use the Wisconsin Assessment of the Impaired Driver (WAID) to determine whether drivers need education, treatment, or both to reduce the likelihood they will drive impaired in the future.

DRIVER SAFETY PLAN

A driver safety plan is prepared following the assessment. You are required to complete the driver safety plan to have driving privileges restored. Kewaunee County will keep all information strictly confidential.

ASSESSMENT FEE & FORMS

You must **pay the assessment fee and complete the forms** in the registration packet before Kewaunee County will schedule an assessment interview.

The cost of the assessment is **$275.00.** Kewaunee County accepts cash, money order, check and credit cards. Credit cards have an additional 2.39% convenience fee. Kewaunee County will charge an additional $150 fee if you do not call **24 hours** in advance should you need to change or cancel your appointment.

Email the completed forms to HSclinics@kewauneeco.org or return the forms to the Kewaunee County Department of Human Services at the address above. Please note this email address is a no-reply email address.

OUT OF STATE RESIDENTS

Contact the Kewaunee County Department of Human Services for a referral to an agency in your home state to complete the assessment and driver safety plan. There is a $50 fee for this referral service. You will need to meet the requirements of Wisconsin Law to drive in Wisconsin in the future.

PATIENT REGISTRATION INFORMATION

Date: ___/___/_____

Patient's Last Name: _____ First Name: _____ Middle Initial: _____

Maiden Name _____ Social Security Number: ____ - ____- _____ Date of Birth: ___ / ___/ ____

Sex: ☐M ☐F ☐Other Marital Status: ☐Separated ☐Single ☐Married ☐Divorced ☐Widowed

Primary Language: _____ Race/Ethnicity: _____

Home Address: _____ Apt#: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (____) _____- _____ Cell Phone: (____) _____- _____

Occupation: _____ Employer: _____

Employer Address: _____ Employer Phone: (____) _____- _____

Emergency Contact: _____ Emergency home phone: (____) _____- _____

Emergency Relationship: _____ Emergency work phone: (____) _____- _____

If you are under 18 years of age, have a legal guardian, or representative payee, please fill out this area:

Father: _____ D.O.B.: _____ Phone: (____) _____- _____

Mother: _____ D.O.B.: _____ Phone: (____) _____- _____

Guardian: _____ _____ Phone: (____) _____- _____

Representative Payee: _____ Phone: (____) _____- _____

Who do you live with? ☐Mother and Father ☐Father ☐Mother ☐Legal Guardian

☐Other: _____ Relationship: _____

Student at: _____ Grade: _____

Referred by: _____

Cultural/Spiritual/Religion? ☐Yes ☐No If yes, Religion: _____

Are you a Veteran? ☐Yes ☐No

Are you working with a probation agent? ☐Yes ☐No If yes, name of agent: _____

Please check which of the following services you are interested in:

☐Operating While Intoxicated (OWI) – Driver's License#: _____ County of Conviction: _____

☐Mental Health Counseling

☐Psychiatrist (Medications)

☐Alcohol/Other Drug Abuse Counseling (AODA)

Please describe why you are seeking services:

_____

_____

_____

_____

Current Medications:

Medication	Dosage	Time of Day	Prescribing Doctor
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Allergies:

Medication	Adverse Reaction
_____	_____
_____	_____
_____	_____

OPTIONAL:

Name of Primary Physician: _____
Address: _____
Phone #: (____) _____- _____
Date of Last Visit: _____

Name of Dentist: _____
Address: _____
Phone #: (____) _____- _____
Date of Last Visit: _____

Name of Eye Doctor: _____
Address: _____
Phone #: (____) _____- _____
Date of Last Visit: _____

INSURANCE INFORMATION (Please provide copy of both sides of insurance cards)

Insurance Company Name: _____ Phone: (____) _____- _____
Address: _____City: _____ State: _____ Zip _____
Policy holder name: _____ D.O.B.: _____ SSN _____ - ____- _____
Relationship to Patient: _____ Policy #: _____ Group #: _____
Employer: _____ Phone: (____) _____- _____
Does your insurance require you to see certain providers? ☐Yes ☐No
If yes, is Kewaunee County a member of your network? ☐Yes ☐No
Is Prior Authorization required? ☐Yes ☐No Phone: (____) _____- _____
Medical Assistance #: _____ Medicare #: _____
VA/Champus#: _____ Any other insurance? _____
(If yes, present card/information)
If a minor, who has legal custody? _____

ONLY IF UNINSURED – Drop off supporting documents or submit to HSclinic@kewauneeco.org

Gross household income: $ _____ per month
Unearned income: $ _____ per month (child support received, unemployment, disability, etc.)
Number of persons, including self, who live on this income: _____
Court ordered obligations: $ _____ per month (child support paid, fines, and probation fees)

DISCLAIMER AND SIGNATURE

I certify that my answers are true and complete to the best of my knowledge. I agree to provide any additional information requested by Kewaunee County to determine my right to receive a reduced fee for services.

I authorize payment to the Kewaunee County Department of Human Services of the benefits herein, specified and otherwise payable to me, but not to exceed the Agency's regular charges for this period of treatment. I understand that if I have not provided full insurance, Medical Assistance, Medicare benefit information, I will be liable for the full cost of the services provided.

I authorize the Kewaunee County Department of Human Services to release a copy of any or all of my medical records, including records received from other agencies to my insurance company, Medical Assistance, Medicare Intermediary, the Health Care Financing Administration and its agents, to be used for the sole purpose of securing payment to the Kewaunee County Department of Human Services. I understand that I have a right to inspect and receive a copy of the material disclosed if I request one.

I understand that this consent is revocable at any time and this consent remains in full force until termination of treatment.

Patient Signature: _____ Date: ___/___/_____
(Age 16 or older)

Parent/Legal Guardian Signature: _____ Date: ___/___/_____

FOR OFFICE USE ONLY:

Is the family currently being billed for State or County funded service relating to mental health, AODA, developmental disabilities, social services, youth corrections services? ☐Yes ☐No

Medicaid Co-pay: _____

Personal liability per month: _____

No financial ability to pay: _____

CREDIT CARD AUTHORIZATION

I, _____ hereby authorize Kewaunee County Department of Human Services to charge my credit card:

Amount Due:	$275.00
*Convenience Fee:	$6.57
Total Due:	**$281.57**

☐ This is a one-time authorization

☐ This is a monthly authorization on the _____ day of each month.

CARD INFORMATION

Credit Card Brand: _____ If other: _____

Credit Card Type: _____

Flex spending charges are acceptable to Human Services if acceptable to your plan.

Name on Card _____

Credit Card Number: _____

Expiration Date: _____

Security code: _____

(3 or 4-digit number on back of card)

Cardholder Signature: _____ Date: _____

☐ Electronic Signature Accepted

Signature not available, verbal permission granted

Cardholder's Billing Address: _____

City, State, Zip: _____

Phone Number: _____

*** I understand and agree that the greater of $1.50 or a 2.39% convenience fee will be added to the amount charged and I agree with this additional fee.**

C&F – M:Drive >Financial >Credit Card Form