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
(920) 388-7030

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 HSclinic@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: ___________________

HEALTH 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: ______________________