CALUMET COUNTY
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Courthouse, 206 Court Street, Chilton, WI 53014
Todd M. Romenesko, Director

Human Services	Public Health Home Health and Hospice	Aging & Disability Resource Center	Child Support
(920) 849-1400	(920) 849-1432	(920) 849-1451	(920) 849-1454

From Appleton: (920) 989-2700 **Crisis Line**: (920) 849-9317; (920) 832-4646 **Website**: www.co.calumet.wi.us

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 allow parents input into developing 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 form 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 $200.00. One-half of the fee ($100.00) must be prepaid to the Department of Health and Human Services by each party before an appointment for mediation can be set. Payments can 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
Name		
Address		
Date of Birth		
Telephone		
Attorney: Name		
Address		
Phone #		

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 the problem:

Please describe what you feel might be a solution to the problem:

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

_____ _____

Signature **Date**

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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?

2. Has Calumet County Department of Human Services ever been involved with the family? If so, When? 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 believe that parents or family members have problems with alcohol or drugs? Have they been in treatment?

6. Have there been members in the family convicted of driving while under the influence of alcohol or drugs?

7. Have there ever been any physical, verbal or psychological abuse, or threats to personal safety between you and the other party? Please describe.

8. Do you have any concerns now about your physical or emotional safety with the other parent?

9. Are there now, or have there ever been, any Orders of Protection or any Restraining Orders? (If yes, you must include the Restraining Order with this form.)

10. Are you afraid to meet with the other party and the mediator?

11. Do you feel ready to work on a parenting plan? If no, Why?

12. Were you afraid to answer these questions. If yes, Why?

13. 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: _____

_____

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: _____

Other people in your household:

Name	Date of Birth	Relationship to You

Who referred you to this Department?_____

Reason you are requesting service?_____

_____

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	☐ You	☐ Other Family Member
Supplemental Security Income/ SSI	☐ You	☐ Other Family Member
Food Stamps	☐ You	☐ Other Family Member
AFDC	☐ You	☐ Other Family Member
General Relief	☐ You	☐ 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 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 Human Services will not leave messages at your home or work place that might identify you as a client of the Department unless you provide specific authorization for such message.

If it is agreeable for messages to be left at your home or work place, 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 Human Services to contact me in the following manner:

1. At my home phone number of _____ or
   E-mail address of _____.
   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: _____
   Phone number: _____ or
   Email address: _____
   The best time to contact me is: _____
   The following instructions are to be followed:

   _____

   _____

3. Other:

   _____

   _____

4. Emergency Contact information:
   Emergency Contact person: _____
   Phone: _____

I also give Calumet County Department of Human Services authorization to contact my insurance company to obtain any necessary prior authorization.

Verbal Authorization: _____ Date: _____
(Staff Signature)

Client Signature: _____ Date: _____