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| **DEPARTMENT OF HEALTH SERVICES**  Division of Care and Treatment Services  F-00335 (02/2024) | | | |  | | | **STATE OF WISCONSIN** | | | | |
| **voluntary agreement for CRISIS STABILIZATION services**  Use of this form is voluntary. This form meets the requirements of Wis. Stat. ch. 48 and Wis. Stat. § 51.15. | | | | | | | | | | | |
| I (we) hereby request the |  | | | | County Department of Human Services / Social Services / | | | | | | |
| Community Programs to place my child | |  | | | | , born on | | |  | | , |
|  | | Name of Child (First, MI, Last) | | | |  | | | Date of Birth (mm/dd/yyyy) | |  |
| in a foster home, group home, shelter care facility, or residential care center for the purpose of crisis stabilization.  I understand that this stay is for purposes of crisis stabilization services only and does not constitute an “out-of-home placement” for purposes of child protective services or juvenile justice services. I retain all parental rights and responsibilities. The county child welfare agency, or in Milwaukee County, the Division of Milwaukee Child Protective Services, does not have placement and care responsibility for my child. I understand I may terminate this agreement at any time and that a child 14 years of age or older must consent to the agreement and cannot be held by the care provider against the child’s will.  I understand that crisis stabilization services under this voluntary agreement shall not exceed five (5) days (a day is considered a consecutive 24-hour period). In the event that these time frames need to be extended and my child is still not able to return home, the county child welfare agency, or in Milwaukee County, the Division of Milwaukee Child Protective Services, will be notified, and other types of voluntary placement agreements, or temporary physical custody action, may become necessary.  I understand that I may be held financially responsible for all or a portion of the costs that may incur during my child’s stay in crisis stabilization. I agree to cooperate with the county department in determining my portion of costs for my child. If determined to be financially responsible, I consent to communication with any and all insurers. | | | | | | | | | | | |
| Name – Parent or Legal Guardian | | | | | | | | | | | |
|  | | | | | | | | | | | |
| Street Address | | | City | | | | | State | | Zip | |
|  | | |  | | | | |  | |  | |
| Name – Crisis Stabilization Provider | | | | | | | | | | | |
|  | | | | | | | | | | | |
| Street Address | | | City | | | | | State | | Zip | |
|  | | |  | | | | |  | |  | |
| **SIGNATURE** – Parent or Legal Guardian | | | | | | | | Date Signed | | | |
|  | | | | | | | |  | | | |
| **SIGNATURE** – Child | | | | | | | | Date Signed | | | |
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