

MICHAEL H. SEIBEL SUPERVISED VISITATION & EXCHANGE CENTER

COUNTY REFERRAL FORM

For appropriate services to be provided, we require that all information is filled out with the appropriate contact information. Please allow 2-3 business days for us to process the referral. All clients must go through an orientation before services are provided. All referrals to be send to seibel@prc-austinmn.org.

Date of referral: _____ County referring: _____

COUNTY SOCIAL WORKER CONTACT INFORMATION

Case worker name: _____ Phone number: _____

Email: _____

GUARDIAN AD LITEM CONTACT INFORMATION

Guardian ad Litem name: _____ Phone number: _____

Email: _____

TYPE OF SERVICE NEEDED

- Supervised Visitation:** provides a safe option for non-custodial parties to visit with their child(ren) with constant supervision.
- Supervised Exchange:** exchanges of the child(ren) from one party to the other without any contact between the parties.
- Virtual Visitation:** provides a unique opportunity for family members to connect with constant supervision via the Zoom or Teams platform. Typically done in 15 minute increments, up to one hour depending on the age of the child (ren).
- Sibling Visitation:** provides siblings who are placed in different homes the opportunity to connect in a safe, positive, and healthy environment. Children must be of school age and potty trained.
- Transitional Visitation:** helps families transition from constant supervised to unsupervised parenting time. Families are monitored through the security office and no staff is in the same room as the families.

SUPERVISED VISITATION/EXCHANGE DETAILS

What is the reason for the services? _____

Who is responsible for the payment of services? _____

Describe the frequency of when visitations/exchanges should occur: _____

Are there any order for protections in place (OFP, HRO, DANCO)? Yes No

If yes, please describe **AND** attach copy of order: _____

When was the last time visiting party had contact with child(ren)? _____

Are additional visitors allowed? Yes No

If yes, please list everyone's name, date of birth, and relationship to the child(ren) _____

Note: All additional visitors must complete an orientation before they are able to be apart of services.

VISITING PARTY(S) CONTACT INFORMATION

Name: _____ Date of Birth: _____

Relationship to child(ren): _____ Phone Number: _____

Address: _____ Email Address: _____

Name: _____ Date of Birth: _____

Relationship to child(ren): _____ Phone Number: _____

Address: _____ Email Address: _____

PLACEMENT(S) CONTACT INFORMATION

Name: _____ Date of Birth: _____

Relationship to child(ren): _____ Phone Number: _____

Address: _____ Email Address: _____

Name: _____ Date of Birth: _____

Relationship to child(ren): _____ Phone Number: _____

Address: _____ Email Address: _____

CHILD(REN) INFORMATION

Name	Date of Birth	Gender	Health Concerns
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Release of Information

Micheal H. Seibel Center
105 First Street SE, P.O. Box 505
Austin, MN 55912
Phone: 507-434-7550
Fax: 507-434-7554

I, _____, D.O.B _____,
have agreed to receive services from the Micheal H. Seibel Family Visitation & Exchange Center. I understand that the execution of this Consent and Release Form is a condition of my participation in **Supervised Visits/Exchanges**.

I authorize Disclosure, Mutual Release, and Sharing of Private Information among the following entities:

- Mower County Sheriff's Office / Jail
- Department of Public Safety
- Mower County Health & Human Services
- Mower County Financial Assistance
- Mower County Social Services
- Mower County Child Support
- Independent Management Services (IMS)
- Quality Case Management
- SEMCAC
- Parenting Resource Center
- Crime Victims Resource Center
- Mayo Clinic Health Systems
- Advanced Correctional Healthcare (ACH)
- Welcome Center
- Fountain Centers
- Workforce Development Inc.
- Guardian Ad Litem: _____
- Social/Case Worker: _____
- Attorney: _____
- Other: _____

Information to be disclosed:

- | | |
|--|---|
| <input type="checkbox"/> Attendance Information | <input type="checkbox"/> Critical Incident Reports |
| <input type="checkbox"/> Observation Notes | <input type="checkbox"/> Concerns |
| <input type="checkbox"/> Termination of Services | <input type="checkbox"/> Visitation/Exchange Schedule |

(Form/s) of Disclosure:

- | | |
|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> E-mail | <input type="checkbox"/> In Person |
| <input type="checkbox"/> Fax | <input type="checkbox"/> Phone |
| <input type="checkbox"/> Postal mail | <input type="checkbox"/> Other: _____ |

Please Note, any information released via email may be read by unintended parties. Once the Seibel Center has released information to a third party, we are no longer in control of what is done with that information.

This authorization is voluntary. I understand that my records are protected under certain governmental and ethical regulations and cannot be released without my written consent or unless subpoenaed by a court of law. The Seibel Center reserves the right to disclose information upon request by appropriate parties or when there is a concern for the safety and well-being of participants and/or staff. I understand that I may revoke this authorization at any time by giving written notice. This authorization will expire one year from the date of signing. A photocopy of this form shall be as valid as the original.

Participant's Signature: - _____ Date: _____

Coordinator: _____ Date: _____