**Name**:_____ **Date**:_____

***This form should be filled out by the Mental Health Court applicant***. In order for the Mental Health Court Judge and Team to determine whether or not you are eligible for Mental Health Court, we need you to give us some information about your history. **Please circle "Yes" or "No" after each question**. **If the question asks for an answer, do your best to answer it.** If you need more room, please use the back of this form. If you have any questions, call the Mental Health Court at 208-287-7507. **Remember, there are no right or wrong answers!**

1. Do you have a mental illness? ..... **Yes** **No**
2. Do you live in Ada County? ..... **Yes** **No**
3. If you do not live in Ada County, are you planning to move to Ada County? ..... **Yes** **No**
4. If you live or plan to live in Ada County, please tell us **exactly where** you will live, **who** you will live with, and **when** you can (or did) start living there: _____

   _____

   _____
5. What is your mental illness (diagnosis)? _____
6. Who diagnosed your illness and when did they diagnose you? _____
7. Are you currently being treated for your mental illness? ..... **Yes** **No**
8. Where do you receive treatment for your mental illness? _____
9. What medications do you take for your mental illness? _____

   _____
10. Do you have any substance abuse or addiction issues**?** ..... **Yes** **No**
    **(NOTE: Having a substance abuse problem doesn't stop you from being eligible.)**
    a. What is your drug of choice?_____
    b. How old were you when you first used your drug of choice?_____
    c. How do you typically use you drug of choice? (smoke, IV, snort, swallow etc.) _____
    d. When did you last use your drug of choice? _____
    e. When did you last use any drugs/alcohol? _____
11. Have you ever suffered from a traumatic brain injury? ..... **Yes** **No**
12. Do you have a learning disability or are you developmentally delayed? ..... **Yes** **No**
    (You may still be eligible for Mental Health Court, but this information is important for the team to have.)
    a. What grade did you complete in school? _____
    b. Were you ever in any special education classes? _____
13. Are you required to register as a sex offender? ..... **Yes** **No**
14. Have you been prosecuted for any violent crimes? ..... **Yes** **No**

## Defendant Application Questionnaire

15. Please list all crimes **you have been prosecuted for** in the past (use other side as needed, please): _____

_____

16. Have you ever been on probation? ..... **Yes** **No**

17. If yes, in what **county** and **who was your P.O.**? _____

18. If you have children, please list their names, ages, and who takes care of them: _____

_____

19. Are you currently receiving **Voc Rehab or PSR**?…….. **Yes** **No**
    If yes, please list the agencies (use the back of the page as needed):_____

20. Were you ever in the military? If yes, which branch? _____

21. What is your current source of income? _____

Why do you want to be in the Mental Health Court? _____

_____

_____

_____

_____

_____

Who filled out this form? _____

**IN THE DISTRICT COURT OF THE FOURTH JUDICIAL DISTRICT OF THE**

**STATE OF IDAHO, IN AND FOR THE COUNTY OF ADA**

STATE OF IDAHO

Plaintiff,

vs.

_____,

Defendant.

Case No. _____

**CONSENT FOR DISCLOSURE OF CONFIDENTIAL MENTAL HEALTH, MEDICAL AND SUBSTANCE ABUSE INFORMATION**

I, _____, hereby give my permission for an open exchange of information among provider(s) of the members of the Ada County Mental Health Court team, including the following agencies/parties. Please note that ALL LINES MUST BE INITIALED.

_____ Ada County Mental Health Court Presiding Judge Steven Hippler,

_____ District Judge/s _____ (referring judge/s),

_____ Ada County Deputy Prosecuting Attorney Maria Gonzalez or her designated representative,

_____ Ada County Public Defender Meagan Roumanis or her designated representative,

_____ Forensic Assertive Community Treatment (FACT) Team, Idaho Department of Health and Welfare, Region IV, including Amber Hagler, Sarah Rosenbloom, Brian Wixom, Miguel Arambul and collateral IDHW staff and/or as appropriate,

_____ Idaho Department of Correction, District IV Community Corrections Probation and Parole Agent Patty Sproat and/or her designated representative,

_____ Idaho Department of Corrections, Pre-Sentence Investigation ("PSI") Unit,

_____ Ada County Mental Health Court Coordinator Laura Kiehl, Assistant Coordinator Alice Shriver,

_____ Ada County Sheriff's Office, including but not limited to Deputy Brian Maddox and Deputy Kim Johnson,

_____ Idaho Division of Vocational Rehabilitation representative Debbie Barker and her designee(s),

_____ Other education, vocational, medical or health providers or agencies, providing services to Ada County Mental Health Court participants,

_____ Local law enforcement agencies, but only as such information is needed for gathering history, monitoring my case and compliance with mental health court conditions of participation,

_____ Ada County Treatment Services (A.C.T.S.), for drug testing purposes and collateral information, if required to drug test at this location,

_____ Ada County Misdemeanor Probation,

_____ Recovery 4 Life substance abuse treatment provider including Amy Jeppesen, Cloeie Hood, Sarah Samson and their designated representatives

_____ (Housing provider), _____

_____ Other:_____

_____ Other: _____

_____ Other: _____

The purpose of, and need for, this disclosure and exchange of information is to provide information about my eligibility and/or acceptability for Mental Health Court and about the nature of the substance abuse treatment services I need. The information to be exchanged may include information about my diagnosis, treatment plan, treatment attendance, program compliance, progress, and prognosis, as this information relates to the Mental Health Court conditions of each phase of participation and progress monitoring criteria. This information will allow the team to plan and coordinate services I need, to impose appropriate sanctions or rewards based on my behavior, to submit billings for services, to audit, evaluate, or conduct legitimate research about Mental Health Court activities and effectiveness, and will also allow any persons named in this consent (such as family members) to be involved in my Mental Health Court activities. I further understand that some or all of this information will be discussed in **open court**, where any person in the courtroom may hear the information. The nature of the information to be shared will include, but is not limited to: arrest and prior criminal record, intake and pre-sentence investigation report information, risk and alcohol/drug use assessment and diagnosis information, treatment plans, court directives, drug test results, progress reports, program compliance and other related behavior, and recommendations for services, sanctions and rewards.

Disclosure of this otherwise confidential information may be made only as necessary for, and pertinent to, hearings, case planning, and/or reports concerning this case. No person, other than as listed above, will have access to this information without my further consent.

I understand that this consent will remain in effect and cannot be revoked by me until there has been a formal and effective termination of my involvement with the Mental Health Court for the above referenced case, either by my successful completion of the Mental Health Court requirements OR upon sentencing for violating the terms of my Mental Health Court involvement. I agree that the release of the above information, prior to Mental Health Court termination and/or sentencing, shall not be a breach of my right to confidentiality.

I understand that any disclosure made is bound by Part 2 of Title 42 of the Code of Federal Regulations (42 CFR, part 2), which governs the confidentiality of substance abuse patient records and that recipients of this information may re-disclose it only in connection with their official duties and only with respect to these particular criminal proceedings.

_____
Date

_____ _____
Defendant Printed Name Defendant Signature

_____ _____
Witness Signature Title

_____
Signature of Interpreter (where applicable)

**IN THE DISTRICT COURT OF THE FOURTH JUDICIAL DISTRICT OF THE**

**STATE OF IDAHO, IN AND FOR THE COUNTY OF ADA**

| | |
|---|---|
| STATE OF IDAHO<br><br>Plaintiff,<br><br>vs.<br><br>_____,<br><br>Defendant. | Case No. _____<br><br>**APPLICATION TO PARTICIPATE IN THE ADA COUNTY MENTAL HEALTH COURT** |

I hereby apply for admission into the Ada County Mental Health Court Program. I have read the Ada County Mental Health Court Program handbook. I acknowledge that, as part of the application process:

1. My prior criminal record, if any, will be reviewed to determine whether I am eligible to participate in Ada County Mental Health Court Program.
2. I will be required to complete a Level of Service Inventory-Revised evaluation.
3. I will be required to complete an alcohol/drug screening by an approved treatment provider.
4. I will be required to complete a diagnosis/evaluation by the Mental Health Court Coordinator and/or Idaho Dept. of Health and Welfare Region IV Mental Health.
5. My application, my prior record, the results of the LSI-R, the results of the alcohol/drug screening, and the results of my diagnosis/evaluation will be reviewed by a Mental Health Court team. Admission into the Ada County Mental Health Court Program will be at the sole discretion of the Mental Health Court judge.

If accepted into the Ada County Mental Health Court Program, I agree to comply with the following conditions of admission:

1. I will comply with all requirements contained in the Ada County Mental Health Court handbook.
2. I will sign a probation agreement with the State of Idaho Department of Probation and Parole.
3. I will authorize release of all treatment information to the Mental Health Court team which may include, but not be limited to, my attorney, the prosecuting attorney, the Mental Health Court judge, a representative of probation and parole, the Department of Health and Welfare, and other Mental Health Court team members and treatment providers. This information may be used by the Mental Health Court team to determine my level of participation in and compliance with the Mental Health Court program, to modify my release conditions and/or to decide to terminate my participation in the

program. The information may also be used to modify or terminate probation. *The information will not be used by the prosecuting attorney for the prosecution of any new crime*.

4. I will appear in court for all scheduled hearings.

I understand that any failure on my part to comply with the Ada County Mental Health Court Program requirements may result in modification or revocation of my probation, including the imposition of sentence.

DATED _____

_____
Defendant's Signature

_____
Print Name

*This application should be submitted to the Ada County Mental Health Court at the first Mental Health Court hearing or by fax to (208) 287-7549.*

Ada County Mental Health Court
200 W. Front St., Room 4105
Boise, Idaho 83702
Phone: 208-287-7507

**IN THE DISTRICT COURT OF THE FOURTH JUDICIAL DISTRICT OF THE**

**STATE OF IDAHO, IN AND FOR THE COUNTY OF ADA**

| | |
|---|---|
| STATE OF IDAHO<br><br>Plaintiff,<br><br>vs.<br><br>_____,<br><br>Defendant. | Case No. _____<br><br>**AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL SUBSTANCE ABUSE INFORMATION** |

I, _____, hereby authorize disclosure of all information regarding my diagnosis, prognosis and treatment by _____ (treatment provider) to the Ada County Mental Health Court team. The team includes, but may not be limited to the Judge presiding over the Ada County Mental Health Court, the Mental Health Court Coordinator and staff, the prosecuting attorney, my personal attorney whether privately retained or a public defender, officers from the probation department in the particular county where my case is being handled, representatives from the Idaho Department of Health and Welfare and representatives of the treatment provider.

The purpose of and need for this disclosure is to inform the Mental Health Court and the Mental Health Court team members of my eligibility and/or acceptability for substance abuse treatment services and my treatment attendance, prognosis, compliance and progress in accordance with the Mental Health Court monitoring criteria.

Disclosure of this confidential information may be made only as necessary for and pertinent to hearings and/or reports concerning this case.

This consent is subject to revocation at any time except to the extent that the program which is to make the disclosure has already taken action in reliance on it. I understand that revocation of this consent will result in termination of my participation with Mental Health Court. If not previously revoked, this consent will terminate upon completion of my probation.

I understand that any disclosure made is bound by federal law, specifically Part 2 of Title 42 of the Code of Federal Regulations, which governs the confidentiality of substance abuse and mental health patient and/or client records, and the recipients of this information may re-disclose it only in connection with their official duties.

Dated _____ _____
Defendant

Dated _____ _____
Witness

RECOVERY·4·LIFE

Changing lives one family at a time

**Client Information**

Client Name:_____ DOB: _____
Mailing address: _____
Telephone: _____

**Authorization Details**
*I authorize the following individual, organization, or business*
_____
*to disclose my confidential information to:*
Name: **Recovery 4 Life**
Address: **8950 W Emerald St. Suite 178, Boise ID 83704** Phone: **208-376-7083** Fax: **208-321-5069**
*for the purpose of:* **Mental Health Court Screening**_____

*Please describe in detail the information to be disclosed:* **Psychiatric evaluation, mental health assessment, record of medications, progress/provider notes, discharge summary.**
_____
My authorization is given freely with the understanding that:

- **This release will expire without express revocation after one year or the specified date of :** _____
- My information may be subject to re-disclosure by the recipient and may no longer be protected by Recovery 4 Life's privacy practices or applicable privacy laws.
- Recovery 4 Life may not condition my treatment on my provision of this authorization.
- A photocopy or fax of this authorization is as valid as the original.
- Recovery 4 Life, its directors, officers, employees, agents, and volunteers are hereby released from any legal responsibility or liability for disclosure of the above information, to the extent indicated and authorized herein.
- We are required by law to keep your information confidential. This release of information is limited to the person or agency named and allows for communication among them if that is necessary for your treatment.

This release in its entirety may be revoked at any time either orally or in writing, except to the extent that action has been taken in reliance on the release. I release the named persons and entities from any or all responsibility and liability concerning the release of information for which I have given my consent. I acknowledge that some information may include material that is protected by state and federal regulations including Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2 and Health Information Portability and Accountability Act (HIPPA) of 1996, 45 CFR parts 160 and 164 Subparts A and E, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

Client signature: _____ Date: _____

Agency Representative: _____ Date: _____

# MENTAL HEALTH COURT DEFENDANT INFORMATION SHEET

| | | | |
|---|---|---|---|
| **Defendant's Name** | | **Today's Date** | |
| **Last** | **First** | **Middle** | |
| **AKAs (Also Known As)** | | **Phone Number** | ❑ Home<br>❑ Cell<br>❑ Message |
| **Email Address** | | | |
| **Address** | | | |
| **Street (no Post Office boxes)** | | **Apt/Space Number** | |
| **City** | **State** | **Zip Code** | |
| **Social Security No.** | | **Birthday** | |
| ❑ **Driver's License No.**<br>❑ **Identification Number** | | **Issuing State** | |
| **Employer Name** | | **Phone No.** | |
| **Address** | | | |
| **Street (no Post Office boxes)** | **City** | **Zip** | |
| **Main Vehicle** | | **License Plate No.** | |
| **Year** | **Make** | **Model** | **2 door/4 door** |
| **Secondary Vehicle** | | **License Plate No.** | |
| **Year** | **Make** | **Model** | **2 door/4 door** |

## MESSAGE and/or EMERGENCY CONTACT

| | | | |
|---|---|---|---|
| **Name** | | | |
| **Address** | | | |
| **Phone No.** | | **Relationship to you** | |

## CHILDREN and/or PETS

| | |
|---|---|
| **Names & Ages of Children** | |
| **Address/Responsible Party** | |

## GENERAL PHYSICAL DESCRIPTION

❑ **Male** ❑ **Female**

| | | | |
|---|---|---|---|
| **Height** | Feet Inches | **Weight** | Pounds |
| **Hair Color** | | **Eye Color** | |
| **Other Language** | ❑ Spanish ❑ Sign ❑ Other, specify: | | |

**Ada County Mental Health Court**

# List of Mental Health Care Providers and Psychiatric Hospitalizations

## THIS FORM MUST LIST ALL YOUR PROVIDERS AND HOSPITALIZATIONS!

***If you do not have a history of psychiatric hospitalization or mental health treatment, Mental Health Court may determine NOT to screen you any further***.

In order to screen you for Mental Health Court, we need to collect records from **mental health** providers and hospitals who can verify your diagnosis and **mental health** treatment history. Please fill out this form with as much information as you can. We will ask you to sign release forms for each treatment provider so that we can collect medical records to support your application.

Defendant: _____ Date: _____

| **Provider or Hospital Name** (Please include phone number and address information if you know it.) | **City, State** | **Dates of Treatment** (What month/year did you start seeing this provider, and when did you stop seeing them?) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

If you need more room, please use the back of this form.