

IN THE DISTRICT COURT OF THE FIRST JUDICIAL DISTRICT OF THE
STATE OF IDAHO, IN AND FOR THE COUNTY OF KOOTENAI

STATE OF IDAHO,)	
)	
Plaintiff,)	CASE NUMBER CR-F- _____
)	
V.)	
)	
_____ ,)	APPLICATION FOR ADMISSION
)	INTO KOOTENAI COUNTY MENTAL
Defendant.)	HEALTH COURT
_____))	

I, _____, the above named defendant,
hereby state as follows:

1. I have been convicted of the following crimes for which I am applying for admission in Mental Health Court:

2. I was sentenced by Judge _____ for this/these crimes on _____. (If sentencing or disposition of probation violations is pending, give date of that hearing).

3. There is/is not a probation violation pending. If there is a probation violation pending, a copy of the Report of Violation is attached.

4. This is/is not the first Report of Violation filed. If not the first probation violation, list the outcome of all other probation violation proceedings.

5. A copy of my prior criminal record from my PSI is attached.

6. I need help in dealing with substance abuse issues. Please outline prior treatment efforts and any current treatment programs, with the most recent program listed. Also attach a copy of a recent substance abuse evaluation if one has been conducted.

7. I have also been diagnosed with a mental illness. List mental illness/illnesses, when diagnosed and by whom.

8. List mental health treatment programs attended, with current/most recent program listed first.

9. I currently take the following prescribed medications for my mental illness. If not currently taking medications, please list medications taken in the past, with most recent listed first. Explain why prior medications were discontinued.

10. List all SSI benefits being received. If not currently receiving benefits, list what benefits have been received in the past, and the estimated time for reinstatement of those benefits.

11. I have reviewed the Kootenai County Mental Health Court Participant's Handbook, believe I am eligible for admission into the program, and wish to be accepted for participation in the program.

DATED this _____ day of _____.

Applicant

CERTIFICATE OF DELIVERY

I hereby certify that a copy of the foregoing was served by inter office mail, or by faxing a copy, on the ____ day of _____, addressed to:

Suzanne Witlicki, Coordinator
Kootenai County Mental Health Court ____ fax 446-1224

**Idaho Treatment and Recovery Support Services
DRUG COURT**

Direct any and all questions or concerns to: _____

Consent for Release of Information

I, _____ am requesting substance abuse services from Idaho's publicly funded substance abuse system of care. As such I voluntarily authorize Business Psychology Associates (BPA), those Substance Abuse Treatment and Recovery Support Services (RSS) providers who are contracted to provide Treatment and RSS under Idaho's publicly funded substance abuse system of care, and the Department of Health and Welfare (Department) to disclose my name, all necessary treatment information and my social security number to each other and the Department. This information will be disclosed for the following purposes: **1)** To assist with referring me to appropriate types of care and guiding my treatment and recovery support; **2)** To be entered into the Department's common client database so that I will have one client number for any services received from the Department; **3)** To process payment of costs for my treatment and recovery support services; **4)** For monitoring compliance in the program; **5)** For program audit and research including independent peer reviewers, contract monitors or researchers appointment by the Department; and **6)** So my client number can be used in preparing statistical reports on the number of persons receiving Drug Court treatment/services through the Department

Furthermore, I authorize the disclosure of personal substance abuse treatment and recovery outcomes data collected by contracted Substance Abuse Treatment and RSS Providers, BPA and the Department to the Federal Center for Substance Abuse Treatment and its contracted data collection agents. _____ Client Initials

Informed and Voluntary Consent for Treatment

The purpose of my participation, as a client, in the Idaho publicly funded substance abuse treatment program is to acquire knowledge, skills and attitudes supportive of a sober and more satisfying lifestyle.

In addition to the potential positive outcomes likely to occur as a result of my participation, the following reasonably foreseen risks may occur, as they would in any other alcohol and drug treatment program: breach of confidentiality; negative reactions of group members; emotional stress from requirements of group interaction, self-disclosure; stress to relationships resulting from open discussion of issues, past traumas; and, stress to relationships resulting from participant behavioral changes, positive or negative, need to attend recovery support meetings, spend time in group and doing assignments.

Providers will take steps to minimize or protect participants against potential risks by adhering to standards of confidentiality found both in Federal and State Code, and by informing and verifying client understanding of group rules. And, by intervening in and guiding appropriate disclosure, confrontation and resolution in group and in family conflict. Providers will assist clients in accessing sober support services and self help groups where acceptance and stress reducing support is available. _____ Client Initials

Revocation Clause

This release may be revoked at any time either orally or in writing, except to the extent that action has already been taken in reliance on the release. 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 C.F.R. Part 2 and the Health Information Portability and Accountability Act (HIPAA). Unless revoked as stated above, this consent expires automatically on: _____ Client Initials

I have read the above Consent to Release of Information, Informed and Voluntary Consent for treatment and the Revocation Clause. I agree I have been given the opportunity to question the above disclosures and consent for care and hereby do agree to the above identified Disclosures and Consent to Treatment.

Client Printed Name

Client Signature

Date

Parent/Guardian Printed Name

Parent/Guardian Signature

Date

Witness Printed Name

Witness Signature

Date

**IDAHO ADULT MENTAL HEALTH COURT (MHC) -
 CONSENT FOR DISCLOSURE OF CONFIDENTIAL SUBSTANCE ABUSE INFORMATION**

I, _____, hereby give my permission for an ongoing exchange of
 (Name of Defendant)
 information among _____ and the following individuals and agencies working together in the
 Kootenai County Mental Health Court (MHC):

- MHC Presiding Judge
- Prosecuting Attorney or Deputy Prosecuting Attorney
- Public Defender / other Defense Counsel
- Misdemeanor Probation Staff
- MHC Coordinator / MHC Staff
- Local law enforcement agency personnel, in their capacity as MHC team member
- Idaho Department of Correction Probation or Pre-sentence staff
- Global Drug Testing Services
- Dirne clinic records/services
- Department of Health and Welfare and its substance abuse management contractor
- Other service agencies who are providing services to participants of this MHC
- My victim(s), to the extent my information is in the presentence investigation report
- Kootenai Medical Center
- ACES
- Dept of Health and Welfare, Mental Health Services
- Parole Commission

and also _____
 Name of Person Relationship

and also _____
 Name of Person Relationship

and also _____
 Name of Person Relationship

The purpose of, and need for, this exchange of information is to provide information about my eligibility and acceptability for MHC, about the treatment I need, and about my progress. The information to be exchanged may include information about my diagnosis, treatment plan, treatment attendance, program compliance, progress, and prognosis related to each MHC phase of participation. This information will allow the team to plan and coordinate the services I need, to impose appropriate sanctions or rewards for my behavior, to submit billings for my services, to maintain data about me, and to audit, evaluate, or conduct research about MHC activities and effectiveness. It will also allow any persons named in this consent (such as family members) to be involved in my MHC 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, risk and alcohol/drug use assessment and diagnosis information, treatment plans, court directives, drug test results, progress reports, reports of 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, treatment and/or reports concerning Case No. _____. 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 until there has been a formal and effective termination of my involvement with the MHC for the above referenced case, either by my successful completion of the MHC requirements OR upon sentencing for my original offense, if I am terminated from MHC, OR upon written revocation. I understand that revoking this consent will result in my termination from MHC. I agree that the disclosure of the above information, prior to MHC termination, sentencing, and / or revocation of this consent shall not be a breach of my right to confidentiality.

I acknowledge that my participation in Kootenai County MHC is an informed decision on my part, that I make that decision voluntarily, and that I make that decision knowing which agency is the provider for psychosocial rehabilitation services to MHC. I accept that agency as the provider to me for psychosocial rehabilitation services while I participate in MHC, and I acknowledge this may be a different agency than the agency that is currently providing such services to me.

I understand that any disclosure made is bound by Part 2 of Title 42 of the Code of Federal Regulations (42CFR, 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)