SNOHOMISH COUNTY MENTAL HEALTH THERAPEUTIC COURT
APPLICATION

1. PERSONAL INFORMATION

Name:		
AKA's:		
Date of Birth ***(Must be 18 or older)***:	Email Address:	
Home Phone:	Mobile Phone:	Social Security No.:
Driver's License or ID No.:		State Issued:
Address ***(Must be a resident of Snohomish County)***:		
Emergency Contact, Name & Relationship:		
Emergency Contact Home Phone:	Emergency Contact Mobile Phone:	

2. EMPLOYER INFORMATION

Place of Employment:
Hours/Schedule:

3. ATTORNEY INFORMATION

Attorney Name:	Phone:
Address:	

4. COURT INFORMATION

Current Charge(s):	Case No.:
Current Charge(s):	Case No.:
Are there other criminal charges (or sentences) pending against you, including those in other counties or states? If "yes," explain:	
Are there any court orders pending or in effect against you (includes protection orders, warrants, support orders, etc.)? If yes, Explain.	

5. **MENTAL HEALTH INFORMATION**

Are you receiving mental health treatment now?	If yes, agency:
Have you received prior mental health treatment?	If yes, agency:
Are you receiving substance abuse treatment now?	If yes, agency:
Have you received prior substance abuse treatment?	If yes, agency:
Please list any known mental health diagnosis here:	
Please list any currently prescribed medications here:	

The facts set forth in the application are true and correct to the best of my knowledge, information and belief. I understand that knowingly making a false statement herein is subject to criminal penalties.

Signature of Applicant: _____ Date: _____

My attorney has reviewed this application, releases of information and policies and procedures of Mental Health Court, and I understand this is a voluntary program which, if accepted into the program, requires me to waive certain constitutional rights associated with trial.

Signature of Attorney for Defendant: _____ Date: _____

I understand this application for the Snohomish County Mental Health Therapeutic Court Program will <u>not</u> be further considered without the conditional consent and signature of the Prosecutor. I understand this is not final prosecutor approval in accordance with RCW 2.30.

Conditional Consent and Signature of Prosecutor: _____ Date: _____

Please return this application to the Mental Health Therapeutic Court Clerk at the Everett District Court or Fax 425-388-6397 and provide a copy to the MHC Prosecutor.

THINGS TO REMEMBER

The program takes approximately 12-24 months to complete, but can take up to 24 months if the there are multiple violations.

This is a voluntary program. The client must want to enter the program.

The Mental Health Therapeutic Court Application must be submitted for referral within <u>60 days</u> of Arraignment.

MHC checklist items (including updated mental health evaluation, substance abuse evaluation, intake interview, and Mental Health Court viewing) must be completed within <u>60 days</u> of submitting application.

SNOHOMISH COUNTY MENTAL HEALTH COURT

CONSENT FOR MUTUAL EXCHANGE OF INFORMATION

Mental Health Court Fax Number: 425-388-6397

This information has been disclosed to you from records whose confidentiality is protected by the Federal Confidentiality Regulations (42 CFR, part 2) that prohibits disclosure of records without the specific written consent of the person to whom it pertains, or otherwise permitted by such regulations. A general authorization of release of medical or other information is not sufficient for this purpose.

NAME: _____ **DOB:** _____

I hereby authorize the mutual exchange of information (verbal and written) between the following Mental Health Court Team Members to freely discuss my Mental Health Court case:

Mental Health Court	Prosecutor's Office
Public Defender's Office	Probation Office
Mental Health Agency:	
Chemical Dependency Agency:	
Carnegie Resource Center Reception	
Snohomish County Jail	Other:

I understand Team Members will freely discuss the facts of my case and my compliance or noncompliance in any treatment program. _____ (INITIAL)

I understand any information obtained by this release will be used solely for my participation in the program and will remain confidential between Mental Health Court Team Members. _____ (INITIAL)

I understand that this release is required for my participation in Mental Health Court. _____ (INITIAL)

I further understand that my drug and/or alcohol treatment records are protected under federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 CFR Pts. 160 & 164, and cannot be disclosed without any written consent unless otherwise provided for in the regulations. This Disclosure Authorization is specifically intended to include any diagnosis, testing, and/or treatments for communicable diseases, including sexually transmitted diseases (e.g. Tuberculosis, HIV/AIDS/AIDS related illness), mental health services, drug and/or alcohol services. I also understand that I may revoke this consent in writing at any time except to the extent that this action has been taken in reliance on it, including provisions of heath care services requiring subsequent disclosure to affect payment. Unauthorized re-disclosure by recipient is prohibited, but may be a potential risk. I understand that I do not have to sign this authorization in order to receive health care benefits (treatment, payment, enrollment, or eligibility for benefits) except for health care services necessary to create any assessment or report for disclosure to the recipient identified in this authorization. In any event, this authorization expires automatically as follows:

This release authorization automatically expires 24 months from date of authorization, or termination and/or graduation from the Snohomish County Mental Health Court program, whichever occurs sooner.

_____

Client Signature Date

_____

Attorney / Witness Signature Date