Mental Health Court Referral Form

Personal Information

Last Name:_____**First Name**_____ **Email**_____

Address:_____

City:_____ **State:**_____ **Zip:**_____ **Phone#:**_____**Date of Birth:**_____

Race_____**Ethnicity**_____ **Sex Assigned at Birth:** ☐ **Male** ☐ **Female** ☐ **Intersex**

Social Security Number_____**Drivers License Number**_____

Marital Status: ☐ **Married** ☐ **Single** ☐ **Divorced** ☐ **Widower** ☐ **Living as Married**

Spouse Name_____**Number of Children**_____**Pregnant?** ☐ **N/A** ☐ **Yes** ☐ **No**

Education

Highest Grade Completed:_____ **Current School:**_____

Reading Problem: ☐ **Yes** ☐ **No** **Writing Problem:** ☐ **Yes** ☐ **No** **Did you have an I.E.P.:** ☐ **Yes** ☐ **No**

Employment/Benefits

Source of Income:_____**Employer:**_____

Occupation:_____ **Insurance:** ☐ **Yes** ☐ **No** **Company:**_____

Policy, Group and ID Number:_____

Social Security Benefits: ☐ **Yes** ☐ **No** **Medicare:** ☐ **Yes** ☐ **No** **Medicaid:** ☐ **Yes** ☐ **No Denied**

Benefits: ☐ **Yes** ☐ **No** **Reason:**_____**Date:**_____

Benefits Stopped: ☐ **Yes** ☐ **No** **Reason:**_____ **Date:**_____

Criminal History

Current Charge:_____**Case No.**_____ **Attorney:**_____

Other Cases Pending: ☐ **Yes** ☐ **No** **Out of County Case:** ☐ **Yes** ☐ **No (If yes, list under comments)**

Currently on Probation: ☐ **Yes** ☐ **N o Officer**_____ **Parole:** ☐ **Yes** ☐ **No Agent**_____

Have you completed or been discharged from a Mental Health Court Program in the past three years? ☐ **Yes** ☐ **No** **When?**_____ **Where?**_____

Comments _____

Please Fill Out Both Sides of This Form

Save As Print Clear

Mental Health Court Referral Form - Side Two

Mental Health/Medical

Psychiatric Diagnosis:_____

Psychiatrist:_____ **Address:**_____

City:_____ **State:**_____**Telephone Number:**_____

Psychologist/ Other Clinician_____**Address:**_____

City:_____ **State:**_____**Telephone Number:**_____

Medication/Dosage_____

Medication/Dosage_____

Medication/Dosage_____

Medication/Dosage_____

Have you ever been hospitalized for psychiatric reasons? ☐ **Yes** ☐ **No**

Where:_____**Dates:**_____

Where:_____**Dates:**_____

Where:_____**Dates:**_____

Medical Issues ☐ **Yes** ☐ **No** **Diagnosis**_____

Medication/Dosage _____

Medication/Dosage _____

Substance Abuse

Please List all Drugs you have experimented with

Drug:_____ **Age of First Use**_____**Frequency**_____
Drug:_____ **Age of First Use**_____**Frequency**_____
Drug:_____ **Age of First Use**_____**Frequency**_____
Drug:_____ **Age of First Use**_____**Frequency**_____

Signature:_____ **Date:**_____

Attorney Signature_____**Date:**_____

I acknowledge that my client is applying for Mental Health Court.

IN THE CIRCUIT COURT OF Will COUNTY, ILLINOIS
PROBLEM SOLVING COURT PARTICIPANT
CONSENT FOR RELEASE/DISCLOSURE OF CONFIDENTIAL INFORMATION

I, _____, Case No. _____, authorize:
(Name of Defendant)

☑ The Presiding Judge Frederick V. Harvey and team members of the Will County Problem Solving Courts Program.
(Name of Court)

☑ POs assigned to PSC and representatives of the Will County Adult Probation Department.

☑ ASAs & Clinicians and representatives of the Will County State's Attorney's Office.

☑ APDs and representatives of the Will County Public Defender's Office.

☑ Will Co Health Dept/other agencies contracted with PSC and Behavioral Health Agency representatives.

☑ Family Guidance/other agencies contracted with PSC and representatives of Substance Use Disorder Treatment Provider.

☐ Hines VA and Will County VAC and representatives of any Veterans Health Administration (VHA) hospital or treatment facility or other service provider I am referred to during my participation in the above-named program.

☑ Will County Police Departments and representatives of the Will County Sheriff or any other law enforcement team member.

☑ Courtroom Clerks/Personnel assigned to PSC and representatives of the Chief Judge's Office and any other person permitted by the presiding judge to attend team staffing(s) for training and educational purposes.

☑ Scott DuBois & Mitch Crandall as Problem Solving Court Coordinator

☑ S. Miller, R. Findlay & A. Thompson as Peer Support Specialists.

to communicate with and disclose to one another information concerning the following:

Any evaluation, diagnosis, prognosis, hospitalization, treatment, urinalysis result (including disclosure or test results in open court) or other information concerning my attendance, progress and compliance with treatment, substance abuse disorders, or otherwise related to my health or treatment. The purpose of the disclosure is to inform

the court and other named person(s) listed above of my eligibility for treatment and my compliance and progress in treatment pursuant to the conditions of my court ordered participation in treatment.

I understand that my health and Substance Use Disorder (SUD) records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPPA), 45 CFR Parts 160 & 164, and that my mental health records are protected under the Illinois Mental Health and Developmental Disabilities Confidentiality Act (MHDDCA), 740 ILCS 110/1. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically when there has been a formal and effective termination or revocation of my release from confinement, probation, or parole, or other proceeding under which I was mandated into treatment, or _____.

I understand that I may request a specific list of exactly which records have been disclosed.

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I recognize that my review hearings are held in an open and public courtroom and it is possible that an observer could connect my identity with the fact that I am in treatment as a condition of participation in a Will _____ County Problem Solving Court. I specifically consent to this potential disclosure to third persons.

I understand that if I refuse to consent to disclosure or attempt to revoke my consent prior to the expiration of this consent, that such action is grounds for immediate termination from the Will _____ County Problem Solving Court in which I am enrolled.

I acknowledge that I have 1) been provided a copy of this consent form, and 2) been advised of my rights, have received a copy of the advisement, and have had the benefit of legal counsel or have voluntarily waived the right to an attorney. I am not under the influence of drugs or alcohol. I fully understand my rights and I am signing this Consent voluntarily.

Dated: _____ _____

(Signature of Problem Solving Court Participant)

Witness: _____ _____

(Position)

PROHIBITION ON REDISCLOSURE OF CONFIDENTIAL INFORMATION

This notice accompanies a disclosure of information concerning a client in substance use disorder or mental health treatment, made to you with the consent of such client. This information has

been disclosed to you from records protected by federal (42 CFR Part 2) and Illinois (740 ILCS 110/1) confidentiality rules/law. Those federal and state rules/law prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2 or 740 ILCS 110/1. A general authorization for the release of medical and other information is NOT sufficient for this purpose. The federal and state rules also restrict any use of this information to criminally investigate or prosecute any alcohol or drug abuse or mental health patient.

You may report any violations of your privacy rights to the Department of Health and Human Services. Information and procedures on reporting a violation may be found at www.hhs.gov. Written complaints may be submitted to:

Centralized Case Management Operations
U. S. Department of Health and Human Services
200 Independence Ave., S. W.
Room 509F HHH Building
Washington D. C., 20201

A complaint may be emailed to: ocrcomplaint@hhs.gov.

You may also contact the Illinois Department of Human Services at 1-800-843-6154.