

Mental Health Court Referral Checklist

Forms to be turned in with your referral

- Marinette County Release**-Please have the potential referral **initial the checked lines on the first page and sign and date the back.**
- Marinette County Mental Health Court Referral Form**-Please fill out **ALL** sections of this form. Please be sure to have the potential referral fill out the last 3 questions.
- Documentation of the Mental Illness**-Please include any **medical records** which indicate that the potential referral does have documentation of a severe and persistent mental illness.
- Waiver of Ex Parte Contact with the Treatment Court Judge**-Please review with the potential referral and have the potential referral sign and date.

***Referrals will not be considered until all of the above documentation is submitted. Please send information attention to the Mental Health Court Coordinator via mail or fax. Contact information is below:

Shawn Loch-MHC Coordinator

2500 Hall Avenue Suite A

Marinette, WI 54143

Fax: 715-732-7711

Direct line: 715-732-7686

Email: sloch@marinettecounty.com

For your information

Participant Criteria-This lists the eligibility requirements for Mental Health Court; besides needing to have a diagnosis of mental illness, there are several other requirements one needs to meet in order to be eligible for Mental Health Court. Please review this form before you send a referral.

After all the relevant forms are sent to the Mental Health Court Coordinator, the coordinator will screen the referral and present the referral to the team. The Mental Health Court Team will then make a decision regarding acceptance to Mental Health Court. The coordinator will send a letter to the referring party with the final decision. Please contact the Mental Health Court Coordinator with any questions.

Marinette County Mental Health Court Participant Criteria

Potential candidates must meet the following criteria to be considered for participation in the program:

- Participant must be at least 17 years of age and an established resident of Marinette County, defined as having a physical and voluntary presence in the county, and intent to remain in the county while participating in the program.
- Participant has been diagnosed with a *severe and persistent* mental illness
 - Adults with a serious mental illness are persons: (1) age 18 and over, (2) who currently or at any time during the past year, (3) have a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-V, (4) that has resulted in functional impairment which substantially interferes with or limits one or more major life activities...All of these disorders have episodic, recurrent, or persistent features; however, they vary in terms of severity and disabling effects. **The Marinette County Mental Health Court will accept participants aged 17 if their case is in adult jurisdiction and they otherwise meet this definition.**
- The severe and persistent mental illness **MUST** be the **Primary** diagnosis.
- Participant's Supervision Level Recommendation has been found to be medium to high risk according to the Correctional Officer Management Profiling for Alternative Sanctions (COMPAS) Assessment Tool.
- Participant is likely to benefit from treatment in a community-based setting and has some insight into personal involvement with the criminal justice system.
- Participant should have at least 24 months of supervision left with probation/parole.
- Participants should be facing at least 6 months jail time if convicted, or if already convicted, currently under supervision for a charge with a legitimate potential of at least 6 months jail time if revoked from probation.
- Participant agrees to sign all releases of information, as requested.
- Participant agrees to comply with the Mental Health Court's (MHC) Treatment Conditions/Terms of Participation.

If the potential participant meets one or more of the following criteria, he/she may be ineligible for the program:

- Participant has a medical or psychiatric condition causing a degree of impairment or instability such that it would interfere with program participation, treatment and/or functioning.
- Participant is currently under a Chapter 54 guardianship.
- The level of violence of the current offense will be strongly considered as a factor of admission.
- Participants who have a prior violent crime or weapons charge may be considered at the discretion of the Mental Health Court Team.
- Participant has open warrants.
- Participant understands that if the court discovers a participant meets one or more of the ineligibility criteria after admission, that participant may be terminated from the program.

Final eligibility will be determined at the conclusion of the screening process by the Mental Health Court (MHC) Team



MARINETTE COUNTY
AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Individual's Name: Last Middle First

Home Address:

Home Telephone: Date of Birth:

SPECIFY INFORMATION TO BE DISCLOSED:

Attendance with present and past treatment providers, diagnosis, treatment plans and compliance with same.

MY HIGHLY CONFIDENTIAL INFORMATION:

By signing my name next to a category of highly confidential information listed below, I specifically authorize the use and/or disclosure of the type of highly confidential information indicated next to my signature, if any such information will be used or disclosed pursuant to this Authorization:

- Information about a Mental Illness or Developmental Disability X
Psychotherapy Notes X
Information about HIV/AIDS Testing or Treatment (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative)
Information about sexually transmitted infection
Information about Substance (i.e., alcohol or drug) Abuse X
Information about Abuse of an Adult with a Disability X
Information about Sexual Assault X
Information about Child Abuse and Neglect X
Information about Genetic Testing X

RECIPIENT: Name of person or class of persons to whom Marinette County may disclose my health information:

Marinette County Mental Health Court Team

Address of the recipient or where my health information should be delivered:

2500 Hall Ave, Ste. A, Marinette, WI, 54143

TERM: This Authorization will remain in effect:

- From the date of this Authorization until the day of , 20.
Until Marinette County fulfills this request.
[X] Until the following event occurs: Completion of Mental Health Court
Other:

PURPOSE: I authorize Marinette County to use or disclose my health information (including the highly confidential information I selected above, if any) during the term of this Authorization for the following specific purpose(s): **[Note: "at the request of the patient" is sufficient if the patient is initiating this Authorization]**

Coordination of Care

I understand that once Marinette County discloses my health information to the recipient, Marinette County cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at Marinette County; except, however, if my treatment at Marinette County is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case Marinette County may refuse to treat me if I do not sign this Authorization.

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a completed Marinette County Written Notice of Revocation form to Marinette County's Privacy Officer at the address listed below or to the Human Services Privacy Designee at the address listed below. The revocation will be effective immediately upon Marinette County's receipt of my written notice, except that the revocation will not have any effect on any action taken by Marinette County in reliance on this Authorization before it received my written notice of revocation.

I may contact the Human Services Privacy Designee by mail at Privacy Designee, Marinette County Health and Human Services, Marinette, WI, 54143-1604, by telephone at (715) 732-7760 or by email at hsprivacydesignee@marinettecounty.com.

I may contact Marinette County's Privacy Officer by mail at Privacy Officer, Marinette County Courthouse, Marinette, WI, 54143-1717, by telephone at (715) 732-7417 or by email at humanresources@marinettecounty.com.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize Marinette County to use or disclose my health information in the manner described above.

Signature of Patient

Date

If the patient is a minor or is otherwise unable to sign this Authorization, obtain the following signatures:

Signature of Personal Representative

Description of Authority

Date

Reason for Referral (pending charges, term of probation, ATR) and explanation of how and why criminal behavior is related to diagnosis:

Observable Characteristics of Mental Illness/Distress/AODA:

Previous Drug or Alcohol Treatment (i.e. detox, residential, outpatient, etc.):

Previous Mental Health Treatment (i.e. hospitalization, residential, outpatient, etc.):

General Health Issues/Concerns or Service Connected Disability:

WAIVER OF EX PARTE CONTACT
WITH TREATMENT COURT JUDGE

I understand that prior to my acceptance into a treatment court program, a team of professionals, including the presiding treatment court judge(s), will meet to discuss my case and determine if I am appropriate for participation.

I am making a decision to permit that contact and allow communications between the treatment court team and the Judge without myself or my attorney present.

Further, if I am accepted into a treatment court program, the treatment court team, including the Judge, will meet to discuss my progress. Decisions regarding programming and other recommendations will arise out of these discussions. I understand that these discussions will occur without either myself or an attorney representing me present.

Participant Signature Date

Witness Date