7th Judicial District
Treatment Court Application Packet

IMPORTANT: PLEASE READ ENTIRE PACKET

Attorneys and Probation Officers:
If you are giving this application to a potential Treatment Court Participant, ensure that the applicant understands/reads the Multi-party/Agency Release of Information and initials and signs all designated areas of the packet.

Applicant:
The following Multi-Party/Agency Authorization for Release of Information gives the 7th Judicial District Treatment Courts permission to share protected confidential information. Make sure you are aware of the potential disclosure of your information.

- **COMPLETE** this application packet **IN FULL** to avoid unnecessary delays in processing your application.
- Completed applications can

1) Be turned into the Wood Court mailbox located on the 2nd floor of the Bonneville Law Enforcement Building,
2) Be turned into Brian Mecham, for those presently incarcerated in Bonneville County Jail, and/or
3) Can be mailed to: *Wood Pilot Project; 605 N. Capital Ave; Idaho Falls, ID 83402*
4) In Bingham County, applications may be turned in at the Treatment Court Coordinator Office: *501 N. Maple; Blackfoot, ID 83221*
or via e-mail to: clewis@binghamid.gov Phone number: 208-782-3185

Treatment Court Description

You are not eligible for admission into a Treatment Court if you have not been convicted or plead guilty and sentenced for your crime(s). If you are applying to a treatment court and have not been sentenced you will not be admitted into that treatment court prior to your sentencing.

Seventh District Treatment Courts are intensely structured programs that promote recovery and self-sufficiency. These programs are phase based, requiring the participant to successfully complete phases of the program. All phases are completed by developing competencies that promote recovery and self-sufficiency.

The Treatment Courts integrate treatment for mental health, substance use and criminogenic risks; using manualized, evidence based models that treat individual needs. There is an emphasis on employment, education and other productive activities. Intense supervision is a part of all the Treatment Courts and requires daily call-ins and frequent and random substance use testing which is directly observed by program staff.

The participant is required to attend all assigned treatment activities, comply with supervision, and attend status hearings on a regular basis with the presiding Judge. Participants will also pay a monthly Treatment Court fee in addition to their court fines and cost of supervision.

Once you are accepted into a Treatment Court you will receive a specific handbook regarding that programs outline as well as expected terms and conditions of supervision.

Make sure you complete the entire application:

- If a section *doesn't apply* then write 'D/N/A' in the margin
- If you *don't know* then write 'DK' in the margin.
- **→ or ← are used to signify locations that need your <u>initials</u> or <u>signature</u> to allow the PSCs to consider your application. Failure to do so may void your application.**

Failure to complete the entire application will delay your application process and may result in denial.

Applicant Keep This Page

SEVENTH JUDICIAL DISTRICT TREATMENT COURTS

Notice of Privacy Practices and Confidentiality of Alcohol and Drug Abuse Protected Health Information

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY!

Effective Date: ***March 13, 2008***

Health information which we receive and/or create about you, personally, in this program, relating to your past, present, or future health, treatment, or payment for health care services, is "protected health information" under the Federal law known as the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. Parts 160 and 164. The confidentiality of alcohol and drug abuse patient records maintained by this program is protected by another Federal law as well, commonly referred to as the Alcohol and Other Drug (AOD) Confidentiality Law, 42 C.F.R. Part 2. Generally, the program may not say to a person outside the program that you attend the program, or disclose any information identifying you as an alcohol or drug abuser, or use or disclose any other protected health information except in limited circumstances as permitted by Federal law. Your health information is further protected by any pertinent state law that is more protective or stringent than either of these two Federal laws.

This Notice describes how we protect personal health information (otherwise referred to as "protected health information") we have about you, and how we may use and disclose this information. This Notice also describes your rights with respect to protected health information and how you can exercise those rights.

Uses and disclosures that may be made of your health information:

• **Internal Communications:** Your protected health information will be used within our program that is between and among program staff who have a need for the information. Information may also be shared and among our program and the Department of Health and Welfare, and Business Psychology Associates and their contracted providers in connection with our duty to diagnose, treat, or refer you for substance abuse treatment. This means that your protected health information may be shared between or among personnel for treatment, payment or health care operation purposes. For example: Two or more providers within the program may consult with each other regarding your best course of treatment. The program and the County Clerk's office may share your protected health information with the Department of Health and Welfare and Business Psychology Associates and other billing sources in a billing effort to receive payment for health care services rendered to you. And/or, your protected health information may be discussed within the program about your treatment in connection with others in the program, in an effort to improve the overall quality of care provided by our program. Your protected health information will not be re-disclosed by program personnel and/or the Department of Health and Welfare, and Business Psychology Associates, except as is otherwise permitted herein.

• **Qualified Service Organizations and/or Business Associates:** Some or all of your protected health information may be subject to disclosure through contracts for services with qualified service organizations and/or business associates, outside of this program, that assist our program in providing health care. Examples of qualified service organizations and/or business associates include billing companies, data processing companies, or companies that provide administrative or specialty services. To protect your health information, we require these qualified service organizations and/or business associates to follow the same standards held by this program through terms detailed in a written agreement.

• **Medical Emergencies:** Your health information may be disclosed to medical personnel in a medical emergency, when there is immediate threat to the health of an individual, and when immediate medical intervention is required.

• **To Researchers:** Under certain circumstances, this office may use and disclose your protected health information for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one test or treatment to those who received another, for the same condition. All research projects, however, must be approved by an Institutional Review Board, or other privacy review board as permitted within the regulations, that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Applicant Keep this Page

• **To Auditors and Evaluators:** This program may disclose protected health information to regulatory agencies, funders, third-party payers, and peer review organizations that monitor alcohol and drug programs to ensure that the program is complying with regulatory mandates and is properly accounting for and disbursing funds received.

• **Authorizing Court Order:** This program may disclose your protected health information pursuant to an authorizing court order. This is a unique kind of court order in which certain application procedures have been taken to protect your identity, and in which the court makes certain specific determinations as outlined in the Federal regulations and limits the scope of the disclosure.

• **Crime on Program Premises or Against Program Personnel:** This program may disclose a limited amount of protected health information to law enforcement when a patient commits or threatens to commit a crime on the program premises or against program personnel.

• **Reporting Suspected Child Abuse and Neglect:** This program may report suspected child abuse or neglect as mandated by state law.

• **As Required By Law:** This program will disclose protected health information as required by state law in a manner otherwise permitted by federal privacy and confidentiality regulations.

• **Appointment Reminders:** This program reserves the right to contact you, in a manner permitted by law, with appointment reminders or information about treatment alternatives and other health related benefits that may be appropriate to you.

• **Other Uses and Disclosure of Protected Health Information:** Other uses and disclosures of protected health information not covered by this notice will be made only with your written authorization or that of your legal representative. If you or your legal representative authorize us to use or disclose protected health information about you, you or your legal representative may revoke that authorization, at any time, except to the extent that we have already taken action relying on the authorization.

Your rights regarding protected health information we maintain about you:

• **Right to Inspect and Copy:** In most cases, you have the right to inspect and obtain a copy of the protected health information that we maintain about you. To inspect and copy your protected health information, you must submit your request in writing to this office. In order to receive a copy of your protected health information, you may be charged a fee for the photocopying, mailing, or other costs associated with your request. In some very limited circumstances we may, as authorized by law, deny your request to inspect and obtain a copy of your protected health information. You will be notified of a denial to any part or parts of your request. Some denials, by law, are reviewable, and you will be notified regarding the procedures for invoking a right to have a denial reviewed. Other denials, however, as set forth in the law, are not reviewable. Each request will be reviewed individually, and a response will be provided to you in accordance with the law.

• **Right to Amend Your Protected Health Information:** If you believe that your protected health information is incorrect or that an important part of it is missing, you have the right to ask us to amend your protected health information while it is kept by or for us. You must provide your request and your reason for the request in writing, and submit it to this office. We may deny your request if it is not in writing or does not include a reason that supports the request. In addition, we may deny your request if you ask us to amend protected health information that we believe:

- Is accurate and complete;
- Was not created by us, unless the person or entity that created the protected health information is no longer available to make the amendment;
- Is not part of the protected health information kept by or for us; or
- Is not part of the protected health information which you would be permitted to inspect and copy.

If your right to amend is denied, we will notify you of the denial and provide you with instructions on how you may exercise your right to submit a written statement disagreeing with the denial and/or how you may request that your request to amend and a copy of the denial be kept together with the protected health information at issue, and disclosed together with any further disclosures of the protected health information at issue.

• **Right to an Accounting of Disclosures:** You have the right to request an accounting or list of the disclosures that we have made of protected health information about you. This list will not include certain disclosures as set forth in the HIPAA regulations, including those made for treatment, payment, or health care operations within our program and/or between our program and the Madison County Clerk's office, the administrative boards and committees of Seventh Judicial District Drug Court, the Department of Health and Welfare, Business Psychology Associates and their contracted providers, or made pursuant to your authorization or made directly to

you. To request this list, you must submit your request in writing to this office. Your request must state the time period from which you want to receive a list of disclosures. The time period may not be longer than six years, and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12-month period will be free. We may charge you for responding to any additional requests. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to Request Restrictions:** You have the right to request a restriction or limitation on protected health information we are permitted to use or disclose about you for treatment, payment or health care operations within our program and/or between our program and the Madison County Clerk's office, the administrative boards and committees of the Seventh Judicial District Drug Court, the Department of Health and Welfare, and Business Psychology Associates. While we will consider your request, **we are not required to agree to it.** If we do agree to it, we will comply with your request, except in emergency situations where your protected health information is needed to provide you with emergency treatment. We will not agree to restrictions on uses or disclosures that are legally required, or those which are legally permitted and which we reasonably believe to be in the best interest of your health.

• **Right to Request Confidential Communications:** You have the right to request that we communicate with you about protected health information in a certain manner or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to this office, and specify how or where you wish to be contacted. We will accommodate all reasonable requests.

• **Right to File a Complaint:** If you believe your privacy rights have been violated, you may file a complaint with this office or with the Secretary of the Department of Health and Human Services at:

You will not be penalized or otherwise retaliated against for filing a complaint**.** If you have questions as to how to file a complaint please contact us at the above address.

Our responsibilities:

This office is required to:

- Maintain the privacy of your protected health information;
- Provide you with this notice of our legal duties and privacy practices with respect to your protected health information; and,
- Abide by the terms of this Notice while it is in effect.

This office reserves the right to change the terms of this Notice at any time and to make a new Notice with provisions effective for all protected health information that we maintain. In the event that changes are made, this office will notify you of a revised Notice by mail at the current address provided on your medical file, or provide you with a notice during your next office visit at the current address provided on your medical file.

This notice will be posted where registration occurs at each counseling office location. You have a right to receive a copy of this notice, and all individuals receiving care will be given a hard copy.

OFFICE FOR CIVIL RIGHTS
Medical Privacy, Complaint Division
U.S. Department of Health and Human Services
200 Independence Avenue, SW, HHH Building, Room 509H
Washington, D. C. 20201
Telephone: 866-627-7748 - TTY: 886-788-4989 Email: www.hh.gov/ocr

Applicant Keep this Page

7th Judicial District Treatment Court Application

Name: _____ Date: _____

Applications **will not be processed** until a **guilty plea or verdict** has occurred. Failure to complete/sign/initial **all** of this application packet will **delay** the process of the application.

Date of Birth:	Age:	SSN:
Address: City: State:	Current Location: __Personal Residence __County Jail: _____ __Other: _____	Military Service: **Y / N** Violent Felony Conviction: **Y / N** Sex Offense Conviction: **Y / N** Open Child Protection Case: **Y / N** Parolee **Y/N**
Phone:	LSI score :	
Crime:		Case Numbers:
Probation Officer:	Judge:	Attorney:

Current/Previous Substance Abuse Treatment

Level of Treatment	Provider/Court/Location	Date Range	Successfully Completed
☐Inpatient/residential			Y / N
☐Community Outpatient			Y / N
☐Treatment Court			Y / N
☐Rider program			Y / N
☐Prison			Y / N

Drug Use History

List in Preferential Order	First	Second	Third
Substance			
Route of Administration: *Oral, inhalation, injection*			
Frequency: *Less than 1x p/month; 1-3 x's p/month; 1-2 x's p/week; 3-5 x's p/week; Daily*			
Date last used			
Age at first use			
Cost per day			

Explain why you are applying to be in a 7th Judicial District Treatment Court:

I acknowledge the understanding that I will be required to complete a substance use and/or mental health disorder screening. My prior criminal record, if any, will be reviewed to determine whether I am eligible to participate in a treatment court. I will be required to complete a Level of Service Inventory-Revised (LSI-R) evaluation. My results of the substance use and/or mental health disorder screening / assessment will be reviewed by a treatment court will be at the sole discretion of the specific treatment court team. I may/will be required to receive a literacy and/or education evaluation. Certain treatment courts will require a minimum level of literacy and education.

If accepted into a treatment court, I agree to comply with the following conditions of admission:

(1) I acknowledge that I have reviewed with an attorney the materials and requirements for Treatment Court and any related documents requiring my signature; and I will comply with all requirements contained in the participant handbook of the Treatment Court of which I am accepted.

(2) I will sign a probation agreement with the appropriate probation department, and fully comply with all requirements of probation.

(3) I will authorize release of all treatment information to the treatment court team which may include, but not be limited to, my attorney, the prosecuting attorney, the judge, treatment representatives, a representative of probation and parole and other community partners. This information may be used by the team to determine my level of participation and compliance with the treatment court or to modify my release conditions and/or to 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.

(5) I understand that my probation may need to be extended in order to complete the program in accordance with Idaho Code 19-2601. I understand that any failure on my part to comply with treatment court requirements may result in modification or revocation of my probation, including the imposition of sentence.

Applicant's Signature: _____ Dated: _____

Consent for Disclosure of Confidential Information

I, _____, (Name of Defendant) hereby give my permission for an ongoing exchange of information among the following individuals and agencies working together in (Discretionary Portion) _____ Treatment Court:

- _____, Treatment/ Service Provider
- _____Treatment Court Judge
- Treatment Court Staff
- Prosecuting Attorney or Deputy Prosecuting Attorney
- Public Defender or other Defense Counsel
- Misdemeanor Probation
- Idaho Supreme Court
- Veterans Administration
- Local law enforcement agency personnel, in their capacity as Treatment Court team member
- Idaho Department of Correction Probation or Pre-Sentence Staff
- My victim(s), to the extent my information is in the presentence investigation report
- Idaho Department of Vocational Rehabilitation
- Board of Pharmacy
- Juvenile Probation Staff
- _____, Drug Testing Provider
- _____, Lab Testing Provider
- _____, Dept.of Health and Welfare, Treatment Provider
- _____,Educational or Vocational Program
- _____, Employer

and also _____

Name of Person/ Agency Relationship

and also _____

Name of Person/ Agency Relationship

and also _____

Name of Person/ Agency Relationship

The purpose of, and need for, this exchange of information is to provide information about my eligibility and acceptability for treatment court, 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 treatment court 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 treatment court activities and effectiveness. It will also allow any persons named in this consent (such as family members) to be involved in my treatment 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, risk and needs assessment, alcohol/substance use assessment and diagnosis information, treatment plans, court directives, treatment court 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.(s) _____. 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 I can revoke my consent, but understand that I could potentially be suspended or terminated from the treatment court. I agree that the release of the above information, prior to Treatment Court suspension, 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 (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**

PROHIBITION OF REDISCLOSURE: This information has been disclosed to you from records which may be protected by federal confidentiality rules (42 CFR Part 2). If the information is so protected, the federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted

Background Information

Name: _____
(Print Legibly)

Address _____

Race:
- ☐ White
- ☐ Black
- ☐ Native American
- ☐ Asian

Ethnicity:
- ☐ Puerto Rican
- ☐ Mexican
- ☐ Cuban
- ☐ Other Hispanic

Health Insurance
- ☐ Private
- ☐ Medicaid
- ☐ VA
- ☐ None

Education: *Highest Level of Education Obtained: Check ALL that apply.*

- ☐ Doctorate
- ☐ Masters
- ☐ Bachelors
- ☐ Technical Degree
- ☐ Some College

Type of School:
- ☐ Traditional
- ☐ Technical
- ☐ Online
- ☐ Private

- ☐ Highest Grade Completed _____
- ☐ High School Diploma
- ☐ GED
- ☐ HSE

Type of School:
- ☐ Traditional
- ☐ Alternative
- ☐ Home School
- ☐ Private

Military Service:

Have you served in the United States Military: ☐ No ☐ Yes, if yes Branch: _____ Years of Service: _____ Type of Discharge _____

Currently Pregnant? Yes No

Marital Status: *Please Circle one*: Never Married - Divorced - Separated - Living Together - Married – Widowed

Children

Name *(Last, First, Middle):* _____ In custody of defendant: Yes / No
DOB: _____ Age: _____ Affected by drugs at birth: Yes / No
Child Support: Pay - Receive - N/A Amount $_____ Per month

Name *(Last, First, Middle):* _____ In custody of defendant: Yes / No
DOB: _____ Age: _____ Affected by drugs at birth: Yes / No
Child Support: Pay - Receive - N/A Amount $ _____ Per month

Name *(Last, First, Middle):* _____ In custody of defendant: Yes / No
DOB: _____ Age: _____ Affected by drugs at birth: Yes / No
Child Support: Pay - Receive - N/A Amount $ _____ Per month

Background Information (continued)

Employer: _____ Hourly Wage: $ _____

Hours Per Week: _____ Start Date: _____ Employed at Intake: Y / N

Additional Income *(indicate monthly amount)*: SSI $ _____ SSDI $ _____

VA $ _____ Child Support $ _____

Mental Health History (Current AND Previous)

Please List any/all prescription drugs you are currently or are supposed to be taking & the prescriber:

1)	2)	3)	4)
5)	6)	7)	8)

Have you been diagnosed with any mental illness? Y / N, if yes, please list diagnosis and physician:

Are you currently or are supposed to be taking any psychotropic medications? Y / N

Learning Disability: _____

Traumatic Brain Injury *(list cause(s) & date(s)*: _____

Gang Affiliations *(list all gang involvement)*: _____

History of Violent Crimes *(list all)*: _____

History of Absconding from Probation *(dates & location(s)*: _____

History of Escape *(dates & location(s)*: _____

Treatment Courts are Community Based Programs; this makes it important to know who your Community Support System is. *(Family, friends, clergy, employer, sponsor, other)*

Name	Relationship to You	Phone Number