

SNOHOMISH COUNTY MENTAL HEALTH COURT APPLICATION

1. PERSONAL INFORMATION

Name:		
AKA's:		
Date of Birth (<i>Must be 18 or older</i>):	Email Address:	
Home Phone:	Mobile Phone:	Social Security No.:
Driver's License or ID No.:		State Issued:
Address (<i>Must be a resident of Snohomish County</i>):		
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 use disorder 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.

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

I understand that my application for participation in Snohomish County Mental Health Court will not 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.

Signature of Applicant: _____ Date: _____

I reviewed this application, releases of information and policies and procedures of Mental Health Court with my client. I explained that this is a voluntary program which, if my client is accepted into the program, will require my client to waive certain constitutional rights associated with trial.

Signature of Attorney for Defendant: _____ Date: _____

As the Snohomish County Deputy Prosecutor assigned to Mental Health Court, I am providing conditional consent for entry of the above-named defendant into the Mental Health Court program. This is not final prosecutor approval in accordance with RCW 2.30.

Conditional Consent and Signature of Prosecutor: _____ Date: _____

***Please deliver or fax this completed application to both:
 (1) District Court, Everett Division, fax: (425) 388-6397; AND
 (2) MHC Prosecutor, fax: (425) 388-3572.***

THINGS TO REMEMBER

1. The program takes approximately 12-24 months to complete, but can take longer if there are multiple violations.
2. This is a voluntary program. The client must want to enter the program.
3. **The Mental Health Court Application must be submitted for referral within 60 days of Arraignment.**
4. **Mental Health Court checklist items (including updated mental health evaluation, substance use disorder evaluation, intake interview, and Mental Health Court viewing) must be completed within 60 days of submitting the 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 Treatment Agency:	
Substance Use Disorder Treatment 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 health 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