Veterans Treatment Court Referral Checklist

Forms to be turned in with your referral:

☐ **Outagamie County Treatment Courts Referral Form** – Please fill out ALL sections of this form to the best of your ability. Be sure to have the applicant complete the last 3 questions.

☐ **Waiver of Ex Parte Contact** – Please review this form with the potential participant, and have the potential participant and witness sign on the first page.

☐ **Outagamie County Veterans Treatment Court Team Release** – Please have the potential participant complete the top section of the release and sign and date at the bottom.

☐ **Outagamie County Wisconsin Department of Justice Release** – Please have the potential participant complete the top section of the release and sign and date at the bottom.

☐ **Department of Veterans Affairs Release** – Please have the potential participant complete the patient name and social security number sections in the top, right section of the release and sign and date at the bottom.

☐ **Military History Questionnaire** – Please have the potential participant complete the entire form.

☐ **Copy of DD214 (Military Discharge Form)** – Please include a copy of the applicant's DD214 to confirm his/her military service and character of service.

Referrals will not be considered until the above documentation has been received. Please send the above information to the Veterans Treatment Court (VTC) Coordinator via mail or fax:

Chelsea Niemuth
VTC Coordinator
320 S. Walnut Street
Appleton, WI 54911
Fax: 920-968-4175
Phone: 920-968-5741
Email: chelsea.niemuth@outagamie.org

For your Information:

Veterans Treatment Court Informational Handout: This handout provides an overview of program admission criteria and an overview of program requirements. Please note that meeting eligibility requirements does not guarantee admission into VTC; it is at the discretion of the VTC team.

Referral Process:

1) After all of the relevant forms have been sent to the VTC Coordinator, the Coordinator will review the referral for appropriateness.
2) If the referral is complete and appropriate, the Coordinator will schedule a time to meet with the applicant for a screening interview.
3) Clinical mental health and AODA assessment
4) COMPAS assessment
5) Review of application by the Veterans Treatment Court Team

Please contact the VTC Coordinator with any questions.

OUTAGAMIE COUNTY
TREATMENT COURTS REFERRAL

Treatment Court Applying For:

- ☐ Drug and Alcohol Treatment Court
- ☐ Branch 2 Treatment Court
- ☐ Mental Health Court
- ☐ Veterans Treatment Court

Form Completed by:_____

Phone Number:_____

Referral Date:_____

Outagamie County Resident: ☐ Yes ☐ No

Applicant Name:	Telephone #:	DOB:	Address:
Employment Status:	Last 4 digits of SSN:	Race/Ethnicity:	Referral Source:
Gender Identity:	Language:	COMPAS Score:	Number of Children:
Level of Education:	Insurance/VA Healthcare:	Marital Status:	Housing Type:

Current/Pending Charges and Case Number:	For ATRs- Current Conviction:
Next Scheduled Court Date: Branch:	Type of Hearing (pre-trial, trial, sentencing, etc.):
Current AODA/Mental Health Treatment:	Diagnosis AODA and/or Mental Health:
Previous Participation in Treatment/Diversion Court: ☐ Yes ☐ No Location:	Supervision Status: Agent:
Previous AODA Assessment: ☐ Yes ☐ No Date Completed: Agency:	Served in the US Armed Forces, National Guard, or Reserves: ☐ Yes ☐ No Dates Served: Branch: Discharge:

OUTAGAMIE COUNTY

TREATMENT COURTS REFERRAL

Criminal History

DATE	OFFENSE	LOCATION	DISPOSITION

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:

OUTAGAMIE COUNTY

TREATMENT COURTS REFERRAL

To be filled out by the applicant:

1. Why do you want to join Treatment Court?

2. What goals would you like to accomplish while in Treatment Court?

3. What are you willing to do to accomplish the above goals?

WAIVER OF EX PARTE CONTACT
WITH TREATMENT COURT JUDGE(S)

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(s), 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 Signature Date

AUTHORIZATION FOR DISCLOSURE AND EXCHANGE OF INFORMATION

OUTAGAMIE COUNTY - CRIMINAL JUSTICE TREATMENT SERVICES
320 S. WALNUT STREET, APPLETON WI 54911
920.832.5160 – PHONE 920.968-4175 – FAX

CLIENT INFORMATION

Full Name: _____ **Date of Birth:** _____

TO DISCLOSE / EXCHANGE INFORMATION BETWEEN:

Outagamie County Veterans Treatment Court (VTC) Team	&	Outagamie County Criminal Justice Treatment Services 320 S. Walnut Street, Appleton, WI 54911 Phone: 920.832.5160 Fax: 920.968.4175

PURPOSE OF THE DISCLOSURE:

☒ Coordination of Treatment ☒ Electronic transfer of information (Internet/Fax)
☐ Facilitate Family/Significant Other Involvement ☒ Providing of Services ☒ Other (specify): VTC Coordination & Collaboration

INFORMATION REQUESTING TO BE RELEASED:

- ☒ Assessment
- ☒ Diagnosis
- ☒ Discharge Report
- ☒ Drug Screen Results
- ☒ Education Records/Credits Scores/Transcripts
- ☒ Employment/Vocational Records
- ☒ Medical Records – Inpatient & Outpatient
- ☒ Medications (Prescribed)
- ☒ Program Involvement/Progress
- ☒ Progress Notes
- ☒ Psychological/Psychiatric Evaluation/Diagnosis
- ☒ Recommendations
- ☒ School Academic Records
- ☒ School Attendance Records
- ☒ School Behavior Records
- ☐ School Pupil Service Records
- ☒ Substance Abuse Assessment/Diagnosis
- ☒ Substance Abuse Discharge Summary
- ☒ Substance Abuse Progress Notes
- ☒ Substance Abuse Treatment
- ☒ Treatment Plan
- ☒ Verbal Progress Report/Observation
- ☒ Other (Specify): COMPAS results, military history, military benefit information, any information needed to coordinate care

Comments:

EXPIRATION DATE: This Authorization is good until the following date or event: 6 months post VTC discharge_____
If no date listed, this authorization will expire **one year** from the date signed below.

I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal privacy standards.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

RIGHT TO INSPECT OR COPY THE HEALTH INFORMATION TO BE USED OR DISCLOSED – I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the health information department. I understand that I have the right to inspect and receive a copy of the material to be disclosed as required under HSS 92.05 and 92.06 of the Wisconsin Administrative Code. **RIGHT TO RECEIVE COPY OF THIS AUTHORIZATION** – I understand that if I agree to sign this authorization, which I am not required to do so, I will be provided with a signed copy of the form if I request one. **RIGHT TO REFUSE THIS AUTHORIZATION** – I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above whom I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. **RIGHT TO WITHDRAW THIS AUTHORIZATION**: I understand that written notification is necessary to cancel this authorization. I am aware that my withdrawal will not be effective as to uses and/or disclosures and/or organization(s) listed above have already made reference to this authorization.

NOTE: If signed for Jail Rehabilitation/Education, information gained as a result of the release may be exchanged with Correctional/Jail staff, Wisconsin Department of Corrections staff, and Law Enforcement officers.

Signature: _____ **Date**: _____

☐ **Parent/Legal Representation:** I declare that I am the above named minor child's parent and I represent that I have not been denied access to this child by a court of law and/or denied periods of physical placement with the child.

☐ **Legal Guardian** (Proof of guardianship received) ☐ **Other** (specify): _____

WITNESS: _____ **Date:** _____

A PHOTOCOPY or FACSIMILE OF THIS CONSENT IS AS VALID AS THE ORIGINAL

AUTHORIZATION FOR DISCLOSURE AND EXCHANGE OF INFORMATION

OUTAGAMIE COUNTY - CRIMINAL JUSTICE TREATMENT SERVICES
320 S. WALNUT STREET, APPLETON WI 54911
920.832.5160 – PHONE 920.968.4175 – FAX

CLIENT INFORMATION

Full Name: _____ **Date of Birth:** _____

TO DISCLOSE / EXCHANGE INFORMATION BETWEEN:

Wisconsin Department of Justice, Division of Law Enforcement Services (Treatment Alternatives Diversion Grantor)	&	Outagamie County Criminal Justice Treatment Services 320 S. Walnut Street, Appleton, WI 54911 Phone: 920.832.5160 Fax: 920.968-4175

PURPOSE OF THE DISCLOSURE:
☐ Coordination of Treatment ☐ Electronic transfer of information (Internet/Fax)
☐ Facilitate Family/Significant Other Involvement ☐ Providing of Services ☒ Other (specify): Statistical Analysis

INFORMATION REQUESTING TO BE RELEASED:

☐ Assessment	☒ Medications (Prescribed)	☐ School Pupil Service Records
☒ Diagnosis	☒ Program Involvement/Progress	☒ Substance Abuse Assessment/Diagnosis
☐ Discharge Report	☐ Progress Notes	☐ Substance Abuse Discharge Summary
☒ Drug Screen Results	☒ Psychological/Psychiatric	☐ Substance Abuse Progress Notes
☒ Education Records/Credits	Evaluation/Diagnosis	☒ Substance Abuse Treatment
Scores/Transcripts	☐ Recommendations	☐ Treatment Plan
☒ Employment/Vocational Records	☐ School Academic Records	☐ Verbal Progress Report/Observation
☒ Medical Records – Inpatient &	☐ School Attendance Records	☐ Other (Specify): _____
Outpatient	☐ School Behavior Records	

Comments:

EXPIRATION DATE: This Authorization is good until the following date or event: 6 months post CJTS program discharge (VTC)
If no date listed, this authorization will expire **one year** from the date signed below.

I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal privacy standards.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:
RIGHT TO INSPECT OR COPY THE HEALTH INFORMATION TO BE USED OR DISCLOSED – I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the health information department. I understand that I have the right to inspect and receive a copy of the material to be disclosed as required under HSS 92.05 and 92.06 of the Wisconsin Administrative Code. **RIGHT TO RECEIVE COPY OF THIS AUTHORIZATION** – I understand that if I agree to sign this authorization, which I am not required to do so, I will be provided with a signed copy of the form if I request one. **RIGHT TO REFUSE THIS AUTHORIZATION** – I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above whom I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. **RIGHT TO WITHDRAW THIS AUTHORIZATION**: I understand that written notification is necessary to cancel this authorization. I am aware that my withdrawal will not be effective as to uses and/or disclosures and/or organization(s) listed above have already made reference to this authorization.

NOTE: If signed for Jail Rehabilitation/Education, information gained as a result of the release may be exchanged with Correctional/Jail staff, Wisconsin Department of Corrections staff, and Law Enforcement officers.

Signature: _____ **Date**: _____

☐ **Parent/Legal Representation:** I declare that I am the above named minor child's parent and I represent that I have not been denied access to this child by a court of law and/or denied periods of physical placement with the child.

☐ **Legal Guardian** (Proof of guardianship received) ☐ **Other** (specify): _____

WITNESS: _____ **Date:** _____

A PHOTOCOPY or FACSIMILE OF THIS CONSENT IS AS VALID AS THE ORIGINAL

OMB Number: 2900-0260
Estimated Burden: 2 minutes

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE MEDICAL RECORDS OR HEALTH INFORMATION

Privacy Act and Paperwork Reduction Act Information: The execution of this form does not authorize the release of information other than that specifically described below. The information requested on this form is solicited under Title 38, U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164, 5 U.S.C. 552a, and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if the information including Social Security Number (SSN) (the SSN will be used to locate records for release) is not furnished completely and accurately, Department of Veterans Affairs will be unable to comply with the request. The Veterans Health Administration may not condition treatment, payment, enrollment or eligibility on signing the authorization. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act systems of records notices identified as 24VA19 "Patient Medical Record - VA" and in accordance with the VHA Notice of Privacy Practices. You do not have to provide the information to VA, but if you don't, VA will be unable to process your request and serve your medical needs. Failure to furnish the information will not have any affect on any other benefits to which you may be entitled. If you provide VA your Social Security Number, VA will use it to administer your VA benefits. VA may also use this information to identify veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law. The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 2 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

ENTER BELOW THE PATIENT'S NAME AND SOCIAL SECURITY NUMBER IF THE PATIENT DATA CARD IMPRINT IS NOT USED.

TO: DEPARTMENT OF VETERANS AFFAIRS (Print or type name and address of health care facility)

John H Bradley Mental Health Clinic
14 Tri Park Way, Appleton, WI 54914

PATIENT NAME (Last, First, Middle Initial)

SOCIAL SECURITY NUMBER

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

Outagamie County Veteran's Treatment Court Telephone: (920) 832-5098
320 S. Walnut Street, Appleton, WI 54911 Fax: (920) 968-4175

VETERAN'S REQUEST: I request and authorize Department of Veterans Affairs to release the information specified below to the organization, or individual named on this request. I understand that the information to be released includes information regarding the following condition(s):

☒ DRUG ABUSE ☒ ALCOHOLISM OR ALCOHOL ABUSE ☐ TESTING FOR OR INFECTION WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV) ☐ SICKLE CELL ANEMIA

INFORMATION REQUESTED (Check applicable box(es) and state the extent or nature of the information to be disclosed, giving the dates or approximate dates covered by each)

☒ COPY OF HOSPITAL SUMMARY ☒ COPY OF OUTPATIENT TREATMENT NOTE(S) ☒ OTHER (Specify)

Any documents pertaining to my treatment in order to manage agreement with the Outagamie County Veteran's Treatment Court, the District Attorney's Office and Court System.

PURPOSE(S) OR NEED FOR WHICH THE INFORMATION IS TO BE USED BY INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

To effectively participate in the Deferred Sentencing, Deferred Prosecution, Diversion, and/or Treatment Court agreements; or any other agreement which I have entered into with the Court and/or District Attorney.

NOTE: ADDITIONAL ITEMS OF INFORMATION DESIRED MAY BE LISTED ON THE BACK OF THIS FORM

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing the records. Redisclosure of my medical records by those receiving the above authorized information may be accomplished without my further written authorization and may no longer be protected. Without my express revocation, the authorization will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on _____ (date supplied by patient); (3) under the following condition(s):

2) Upon successful completion or termination from program and disclosure of all discharge paperwork/summaries to respective court.

I understand that the VA health care practitioner's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions.

DATE

SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO SIGN FOR PATIENT (Attach authority to sign, e.g., POA)

FOR VA USE ONLY

IMPRINT PATIENT DATA CARD (or enter Name, Address, Social Security Number)

TYPE AND EXTENT OF MATERIAL RELEASED

DATE RELEASED

RELEASED BY

VETERANS COURT – *Military History Questionnaire*

NAME: _____ LAST FOUR DIGITS OF SOCIAL SECURITY #: _____

1. **Did you ever serve in the U.S. Armed Forces?**

   ☐ **Yes**
   ☐ **No**

2. **Did you ever serve in the U.S. National Guard or Reserves?**

   ☐ **Yes**
   ☐ **No**

3. **In what Branch(es) of the Armed Forces did you serve?**

   ☐ **Army (Including Army National Guard or Reserve)**
   ☐ **Navy (Including Reserve)**
   ☐ **Marine Corps (Including Reserves)**
   ☐ **Air Force (Including Air National Guard and Reserve)**
   ☐ **Coast Guard (Including Reserve)**
   ☐ **Other (Specify) _____**

4. **When did you first enter the Armed Forces? MONTH _____ YEAR _____**

5. **When you were last discharged? MONTH _____ YEAR _____**

6. **Altogether, how much time did you serve in the Armed Forces?**

   Number of Years _____
   Number of Months _____
   Number of Days _____

7. **What type of Discharge did you receive?**

   ☐ **Honorable**
   ☐ **General (Honorable Conditions)**
   ☐ **General (Without Honorable Conditions)**
   ☐ **Other than Honorable**
   ☐ **Bad Conduct**
   ☐ **Dishonorable**
   ☐ **Other (Specify) _____**
   ☐ **Do Not Know**

8. **What was your Military Occupational Specialty (MOS)?**

   _____

9. **Have you been deployed to a combat zone?**

   ☐ **Yes**
   ☐ **No**

10. **Are you a combat veteran?**

    ☐ **Yes**
    ☐ **No**

11. **Total number of deployments: _____**

12. **Dates and locations of deployments:**

    _____

    _____

    _____

13. **Have you ever received services at a VA hospital or clinic?**

    ☐ **Yes: _____**
    ☐ **No**

14. **Have you ever received services at a Vet Center?**

    ☐ **Yes: _____**
    ☐ **No**

15. **Have you ever worked with a County Veterans Service Officer (CVSO)?**

    ☐ **Yes: _____**
    ☐ **No**

16. **Do you receive service-connected disability benefits?**

    ☐ **Yes: _____**
    ☐ **No**

17. **Do you receive a VA pension?**

    ☐ **Yes**
    ☐ **No**

18. **Other information you would like us to know about your military experience:**

    _____

    _____

    _____

SIGNATURE _____ DATE _____

Outagamie County Veterans Treatment Court Program

The Outagamie County Veterans Treatment Court (VTC) program is specifically designated and staffed to handle cases involving participants who have served in the military and struggle with mental illness and/or alcohol and drug use through an intensive, judicially supervised program of substance abuse treatment, mental health treatment, rehabilitation services, and strict community supervision.

Overview of Program Admission Criteria

- At least 18 years of age or adjudicated as an adult
- An established resident of Outagamie County (residence in the city of Appleton outside of Outagamie County may be considered on a case-by-case basis)
- Past or current service member with an honorable discharge ("general" or "other than honorable" may be considered upon investigation)
- Minimum 24 months of probation supervision
- Diagnosed mental health disorder and/or substance use disorder that requires intensive treatment intervention and can be treated with the resources available
- Current COMPAS assessment within the past 12 months, that shows a score of medium to high risk
- Certain violent offenses or sexual offenses are not permitted
- Participants that have a medical or psychiatric condition causing a degree of impairment or instability such that it would interfere with program participation, treatment and/or functioning will not be eligible for programming

Overview of Veterans Treatment Court

- Length of time to complete program is a minimum of 12 months with an additional 6 months of aftercare.
- Regularly attend Veterans Treatment Court review hearings.
- Submit to random drug and alcohol testing. Participants call into the testing hotline every morning to check if they must report for testing that day.
- Complete a weekly log of productive activities. Activities include attending court, treatment sessions, community service, employment, school, or VTC appointments.
- Participate in an individualized case plan, including therapy, groups, supervision, and appointments.
- Participate in Peer-to-Peer Meetings with other veteran participants.
- Have regular contact with a veteran mentor.
- Obey the law and follow the VTC program rules.

Accomplishments and compliance within the VTC program can result in incentives such as:

- Recognition/praise
- Certificate of Achievement
- Phase advancement
- Fee reductions
- Gift certificates
- Travel privileges
- Bus passes

Violations or noncompliance with the VTC program can result in sanctions, based on severity, such as:

- Verbal or written warnings
- Written essays or letter to the court
- Verbal or written apologies to the court
- Community service hours
- Electronic monitoring or alcohol monitoring devices
- Jail time
- Termination from program

For more information, please contact:

Chelsea Niemuth, Veterans Treatment Coordinator
320 S. Walnut Street
Appleton, WI 54911
Direct line: (920) 968-5741
Email: chelsea.niemuth@outagamie.org