Drug and Alcohol Treatment Court Referral Checklist

Forms to be turned in with your referral:

☐ **Outagamie County Release** – Please have the potential participant initial the checked boxes on the first page and sign the second page.

☐ **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 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.

☐ **Documentation of Substance Use Disorder**- Please include any available treatment records which indicate that the potential referral has documentation of a substance use disorder.

****Referrals take at least 2 weeks to process. If an application is submitted, and the court date is less than 2 weeks away, the application will likely not be processed prior to the court day.**

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

Sarah Bassing-Sutton
DATC Coordinator
320 South Walnut Street
Appleton, WI 54911
Fax: 920-832-5488
Phone: 920-832-5270
Email: Sarah.Bassing-Sutton@Outagamie.org

For your Information:

Participation Criteria: This form outlines the eligibility requirements for DATC, please note that meeting eligibility requirements does not guarantee admission into DATC; it is the discretion of the DATC team.

After all of the relevant forms have been sent to the DATC Coordinator, the Coordinator will screen the referral and invite the referral source and any relevant parties to staff the referral with the DATC team. Please contact the DATC Coordinator with any questions.

Outagamie County Department of Health and Human Services
Authorization for Release and Exchange of Health Information

1. _____ _____
Client Name Date of Birth

_____
Street Address City, State, Zip Code

2. AUTHORIZES: Outagamie County Department of Health and Human Services, 320 S. Walnut Street, Appleton, WI 54911 to release protected health information to and receive from:

Outagamie County Drug and Alcohol Treatment Court Team
Name of Health Care Provider/Plan/Other

_____
Street Address City, State, Zip Code

I authorize the above named agencies/individuals to communicate and exchange written and/or verbal information regarding treatment. I release the above named agencies/individuals from all legal responsibilities that may arise from this act. A uniform charge for reproduction will be assessed. I understand the sub-units of the department, which are subject to HIPAA, may exchange confidential information about a client and with any treatment providers who have a services contract with the department if such information is necessary to enable an employee or service provider to do his or her job, or to enable the department to coordinate services for the client.

Date(s) of Service(s): _____ to _____

3. INFORMATION TO BE RELEASED:

PHI			Non-PHI
☑ ____ Diagnosis	☑ ____ Psychological Evaluations		☐ ____ Child Abuse/Neglect Reports
☑ ____ Discharge report	☑ ____ Treatment/Care Plan		☑ ____ Financial Information
☐ ____ Guardianship records	☑ ____ Substance Abuse Assmnt/Diag		☑ ____ Residential Records
☑ ____ History and Physical	☑ ____ Substance Abuse Dischg Summ		☑ ____ School Academic Records
☐ ____ HIV/AIDS status	☑ ____ Substance Abuse Progress Notes		☑ ____ School Attendance Records
☐ ____ Immunizations	☑ ____ Sustance Abuse Treatment		☑ ____ School Behavior Records
☑ ____ Intake/Initial Assessment	☐ ____ X-Ray/Ultrasound Report		☑ ____ School Pupil Service Records
☑ ____ Laboratory results	☐ ____ Pick Up Medications		☑ ____ Vocational Records
☑ ____ Test Results	☐ ____ Check On Appointments		☑ ____ Law Enforcement Records
☑ ____ Progress Notes	☑ ____ Discuss Case Specifics		☑ ____ Court Records
☑ ____ Psychiatric Records/Notes			☑ ____ Other – Specify any information needed to coordinate services

In compliance with Wisconsin Statutes, which require special permission to release otherwise privileged information, please release records pertaining to:

✓ Mental Health	_____ Developmental Disabilities
✓ Alcoholism	✓ Drug Abuse
_____ HIV/AIDS	_____ Sexually Transmitted Diseases
_____ Other (specify): _____	

4. PURPOSE OF DISCLOSURE: (Check applicable categories)

✓ Further Medical Care	_____ Personal
_____ Insurance Eligibility/Benefits	_____ Changing Physicians
_____ Legal Investigation or Action	_____ Other (Specify): _____

5. I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be redisclosed without obtaining my authorization.

6. 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 Privacy Officer at the Department of Health and Human Services, 410 S. Walnut Street, Appleton, Wisconsin, 54911.

- **Right to Receive Copy of This Authorization.** I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form.

- **Right to Refuse to Sign 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 written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawl, I may contact the manager of the division through which I am seeking or receiving services, or the Privacy Officer at the Department of Health and Human Services, 410 S. Walnut Street, Appleton, WI 54911. I am aware that my withdrawl will not be effective as to use and/or disclosures of my health information that the person(s) and/or organization(s) listed above have already made based upon this authorization.

7. **Disclosure of Direct or Indirect Payment Received by Any Person or Organization Authorized to Use or Disclose my Health Information.** I understand that Outagamie County Department of Health and Human Services will not be receiving any direct or indirect payment in connection with the use or disclosure of my health information.

8. **Expiration Date:** This authorization is good until the following date(s):_____
Or event(s) (specify event) Completion of Drug and Alcohol Treatment Court

9. **Not to the Patient and Receiving Agency:** This information has been disclosed to you from records protected by Federal confidentiality rules (42 CRF Part 2). The Federal rules 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 CRF Part 2. A general authorization or the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

Signature: _____ Date: _____

If signed by person other than client, state relationship and authority to do so.

Client Name: _____

Client is: ☐ Minor ☐ Incompetent ☐ Disabled ☐ Deceased

Legal Authority: ☐ Custodial Parent ☐ Authorized Legal Representative
☐ Legal Guardian ☐ Power of Attorney for Health Care
☐ Executor of Estate of Deceased

A PHOTOCOPY OF THIS RELEASE IS AS VALID AS THE ORIGINAL.

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

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?

Drug and Alcohol Treatment Court Eligibility Standards

- At least 18 years of age or adjudicated as an adult
- An established resident of Outagamie County according to the Wisconsin Department of Health and Family Services Residency Manual, as defined by:
    - Physical Presence, Voluntary, Intent to Remain, and Fixed Habitation: stable residence that is fixed on a site and the intent is to remain for the foreseeable future, does not include cars or other motorized vehicles, emergency shelters, CBRF, nursing home, or residential facility where a person's stay is temporary to address acute care needs.
- Minimum 24 months of supervision remaining; if less than 24 remain, probation must be extended
- Current AODA Assessment, within the past 6 months, that shows an active primary diagnosis of substance dependence according to one of the following:
    - Meets criteria for moderate or severe alcohol/substance use disorder according to DSM-5
    - Meets criteria for alcohol/substance dependence according to DSM-IV
- Current Correctional Officer Management Profiling for Alternative Sanctions (COMPAS) assessment, within the past 12 months, that shows a score of medium to high risk, as well as a score of probable to highly probable in the Substance Abuse subcategory; or a score of high on the IDA if OWI is the main legal issue.
- Participant agrees to sign all releases of information, as requested, and comply with the Drug and Alcohol Treatment Court Treatment Conditions/Terms of Participation.
- Previous attempts at AODA treatment and probation
- Violent offenders may be excluded pursuant to the definition set forth in Wis. Stats. Sec. 165.95.
- 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.

Meeting the above criteria does not guarantee admission into the Drug and Alcohol Treatment Court. This will be decided after the Drug and Alcohol Treatment Court Coordinator meets with the person, and staffs with the Drug and Alcohol Treatment Court Team.

Residency Manual (Wisconsin Department of Health Services, 2007).