BENTON COUNTY DISTRICT COURT
THERAPEUTIC COURTS REFERRAL

☐ MENTAL HEALTH COURT
☐ VETERANS COURT
☐ RECOVERY COURT

Please Fax referral packet to: (509) 222-3758

_____
Defendant Name

_____ _____
DOB Referral Date

_____
Current Location (Inmate/Address)

_____
Phone Number

_____
Defense Attorney

Check if DV

Case 1 _____ ☐
Charge _____

Case 2 _____ ☐
Charge _____

Case 3 _____ ☐
Charge _____

List the agency and/or provider(s) where treatment services are received. If not currently receiving services, list the last service provider (REQUIRED):

_____

Mental Health Diagnoses (Required for MHC): _____

_____

Reason for referral: _____

_____

_____

Referred by:
☐ Judicial Officer
☐ Prosecuting Attorney
☐ Other _____
☐ Law Enforcement
☐ Treatment Provider
☐ Jail
☐ Defense Attorney
☐ Probation

_____ _____
Referring Party – Please Print Name Referring Party's Firm/Agency

_____ _____
Referring Party's Telephone Number Referring Party's Email Address

*****ENTIRE REFERRAL PACKET MUST BE COMPLETED*****

IF THE POTENTIAL PARTICIPANT IS REPRESENTED BY COUNSEL, THE ATTORNEY MUST REVIEW AND SIGN THE DOCUMENTS WITH THE POTENTIAL PARTICIPANT

Questions? Please contact the Therapeutic Courts office at (509) 735-8476 ext. 3353

Benton County Therapeutic Courts
7122 W. Okanogan Place Ste A110, Kennewick, WA 99336, (509) 735-8476 ext. 3353

Listed below are the basic requirements of Mental Health Court, Veterans Court, and Recovery Court. You must review the program handbook for a complete list of requirements.

- You must attend regular court hearings and case management appointments. They are scheduled as follows:
  - Phase 1 – weekly
  - Phase 2 – every 2 weeks
  - Phase 3 – every 3 weeks
  - Phase 4 – monthly
- You must commit to 12 months to 24 months of participation (Exact length depends on your progress)
- You may not consume alcohol, use marijuana (or any CBD/THC related products), synthetic drugs, or other street drugs
- You are not allowed to take any mood-altering medications such as opioids, amphetamines, and benzodiazepines
- You must maintain treatment with the agency or provider approved by the Therapeutic Court team
- You must take all of your medications as prescribed
- You must submit to random pill counts to verify medication compliance
- You must check the UA Drug Test Notification line every day (including weekends and holidays) and submit random drug testing (UAs, saliva testing) as requested
- You are required to complete community service hours
- You are required to set goals when you enter the program and you must make continuous progress toward achieving your goals
- You must maintain clean and sober housing and submit your residence to random home visits
- You must attend minimum two therapy appointments per month
- You must see your medication prescriber regularly
- You must participate in any services to which you are referred – substance use disorder treatment, self-help meetings, anger management, domestic violence, etc.
- You must provide documentation of your attendance at all appointments/meetings
- Veterans Court participants must maintain regular contact with their mentor and attend monthly forums

_____ _____ _____

Name Signature Date

Reviewed with: _____, Defense Attorney

BENTON COUNTY DISTRICT COURT
THERAPEUTIC COURTS

AUTHORIZATION TO RELEASE AND EXCHANGE HEALTHCARE INFORMATION

Patient's Legal Name: _____ Date of Birth: _____

I request and authorize the following agencies to release and exchange healthcare information of the patient named above to the Benton County Therapeutic Court teams:

X	Action Counseling	X	Eastern State Hospital	X	Pasco Municipal
X	American Behavioral Health Systems	X	Emmaus Counseling Center	X	Oxford Houses of WA
X	Astria Health	X	First Step Community Counseling	X	Prosser Memorial Health
X	Benton County Corrections	X	Franklin County Probation	X	Reliance Health System
X	Benton-Franklin Dept. of Human Services	X	Grace Clinic	X	Seasons Housing
X	Best Med Urgent Care	X	Grace Collective (Grace Kitchen)	X	Somerset Counseling
X	Catholic Family Services	X	Greater Columbia Behavioral Health	X	SPARC
X	Chaplaincy Health Care	X	Health First Urgent Care	X	Sundown M Ranch
X	Center for Alcohol & Drug Treatment	X	Ideal Option	X	TC Futures
X	Clarvida	X	Kadlec Regional Medical Center	X	Three Rivers Therapy
X	Columbia Basin Veterans Center	X	Lourdes Counseling Center	X	Tri Cities Community Health
X	Compass Career Solutions	X	Lutheran Community Services	X	Trios Health
X	Comprehensive Healthcare	X	Merit Resource Services	X	Triumph Treatment Services
X	Consistent Care	X	Mirror Ministries	X	United Family Center
X	Dept. of Corrections (WA State)	X	MRJN	X	Washington Monitoring
X	Dept. of Children, Youth, & Families (WA)	X	New Start Clinic	X	WA Dept. of Health PMP
X	Dept. of Social & Health Services (WA)	X	Oasis Behavioral Health	X	Yakima Valley Farm Workers Clinic
X	Domestic Violence Services	X	On Scene Medical	X	Other: _____
X	Dr. William Forsythe DO LLC	X	Oregon Recovery & Treatment Center	X	Other: _____

Benton County District Court
Benton County Therapeutic Court
Benton County Public Defender/Prosecutor
Benton County Probation

7122 W. Okanogan Pl. Ste. A110
Kennewick, WA 99336
Phone: (509) 735-8476 ext. 3353
Fax: (509) 222-3758

This request and authorization applies to:

- [X] Medical Diagnosis and Treatment
- [X] Alcohol and Drug Abuse Treatment
- [X] All Mental health information: treatment plans, intake evaluations, medications, relevant progress reports.
- [X] Re-disclosure of all records:

The above information will be used for the purpose of (a) coordinating treatment services; (b) providing referral information; and (c) monitoring for compliance with a treatment program, including informing the court of diagnosis, treatment issues, participation in treatment, attendance or non-attendance, progress, prognosis and completion of treatment. I understand the recipient of the above-requested information may re-disclose it, at which time it may no longer be protected under the privacy laws.

THIS SECTION MUST BE COMPLETED BY PATIENT:

I understand that my records may be confidential, depending on the information contained in them, under one or more of the following statutes or regulations: Medical Records (including mental health records), RCW 70.02; Drug or Alcohol Treatment Records, RCW 70.96A.150 and/or Code of Federal Regulations, Title 42, Volume 1, Part 2 and/or Health Insurance Portability and Accountability Act of 1996, 45 C.F.R. Parts 160 and 164.

X	Yes		No	I authorize the release of any records regarding drug, alcohol, hospitalization, counseling, evaluations, medical, progress reports or mental health treatment to the person(s) listed above.

I understand I do not have to sign this authorization. I understand that at any time I may revoke this authorization; however, the revocation must be in writing. Send to: 7122 W. Okanogan Pl., Ste. A110, Kennewick, WA 99336.

Patient Signature: _____ **Date Signed:** _____

THIS AUTHORIZATION EXPIRES UPON THE END OF THERAPEUTIC COURT JURISDICTION (this includes probationary period).
Note: This authorization may be photocopied for duplication as necessary for the use in gathering additional information.

Benton County Therapeutic Courts
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Participant Demographic Information

Name: _____ Date of Birth: _____

Address: _____

Phone Number: _____ Email Address: _____

RACE: ☐ American Indian or Alaska Native ☐ Middle Eastern ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Hispanic ☐ Multi-racial ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Prefer not to answer ☐ Other: _____

CURRENT LIVING ARRANGEMENT: ☐ Homeless ☐ With Friends/Relatives ☐ Hotel/Motel ☐ Jail ☐ Transitional Housing ☐ Independent Housing (Renting) ☐ Independent Housing (Own) ☐ Shelter

MARITAL STATUS: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Cohabitating

CHILDREN:
Do you have children under the age of 18? ☐ No ☐ Yes – how many: _____
☐ Live with you: _____ ☐ Live with the other parent: _____ ☐ Live with other relative: _____
Have you had your parental rights terminated or relinquished? ☐ Yes ☐ No

CHILD SUPPORT: ☐ N/A ☐ Current ☐ Not current but paying ☐ Not paying at all

EDUCATION LEVEL: ☐ Associate Degree ☐ Bachelor Degree ☐ High School Diploma or GED ☐ No GED/Diploma - Highest grade completed: _____ ☐ Some College, Trade or Technical School

WHAT TYPE OF IDENTIFICATION DO YOU CURRENTLY HAVE?
☐ State Issued ID Card ☐ Driver's License ☐ None

MILITARY VETERAN: ☐ Yes ☐ No
Branch: _____ Dates of Service: _____ Rank at Discharge: _____
Military Status: ☐ Active Duty ☐ Reserves/National Guard ☐ Honorable Discharge ☐ Other than Honorable ☐ Dishonorable Discharge

PRIMARY INCOME SOURCE: Check all that apply
☐ Salary: Full time / Part time ☐ Self-employed ☐ Unemployment ☐ Retirement ☐ Disability ☐ Social Security ☐ VA Disability: _____% ☐ Student ☐ Help from family ☐ Workers Compensation ☐ Adoption Subsidy ☐ Foster Care Subsidy

Total Monthly income: $_____

ASSISTANCE INFORMATION: Check all that apply
☐ No Service/Benefits Received ☐ WIC ☐ Child Support ☐ Food Stamps ☐ TANF ☐ SSI / SSD ☐ VA Benefits ☐ VOC Rehab ☐ Housing Assistance ☐ Childcare Assistance ☐ Other: _____

HEALTHCARE INSURANCE:

☐ None ☐ Medicaid (State Medical) ☐ Medicare ☐ VA ☐ Other/Private:_____

MENTAL HEALTH:

Mental Health Diagnosis: ☐ Schizophrenia ☐ Schizoaffective Disorder ☐ Bi-Polar Disorder ☐ Major Depressive disorder ☐ PTSD ☐ Borderline Personality Disorder

☐ Other: _____

Are you **currently** enrolled in Mental Health Services?

☐ No ☐ Yes at _____

Have you **previously** been enrolled in Mental Health Services?

☐ No ☐ Yes at _____

Prescribed **psychiatric medications**: ☐ Yes ☐ No

Are you taking medications as prescribed? ☐ Yes ☐ No ☐ N/A

Current medications: _____

_____

Other prescribed medications: ☐ Yes ☐ No

Are you taking medications as prescribed? ☐ Yes ☐ No ☐ N/A

Current medications: _____

_____

Prior **in-patient** mental health treatment: ☐ No ☐ Yes – when and where: _____

SUBSTANCE USE:

Are you currently enrolled in **outpatient** SUD treatment? ☐ No ☐ Yes at _____

Prior **outpatient** SUD treatment: ☐ No ☐ Yes at: _____

Prior **residential** SUD treatment: ☐ No ☐ Yes – when and where: _____

History of overdose: ☐ No ☐ Yes – When: _____

PRIMARY Drug of Choice:

☐ None ☐ Alcohol ☐ Amphetamine ☐ Barbiturate ☐ Benzodiazepine ☐ Ecstasy ☐ Cocaine
☐ Fentanyl ☐ Hallucinogens ☐ Heroin ☐ Inhalants ☐ Marijuana ☐ Methamphetamine ☐ Opiates

How often have you used in the last 30 days: _____ Age of FIRST use: _____ Date of last use: _____

SECONDARY Drug of Choice:

☐ None ☐ Alcohol ☐ Amphetamine ☐ Barbiturate ☐ Benzodiazepine ☐ Ecstasy ☐ Cocaine
☐ Fentanyl ☐ Hallucinogens ☐ Heroin ☐ Inhalants ☐ Marijuana ☐ Methamphetamine ☐ Opiates

How often have you used in the last 30 days: _____ Age of FIRST use: _____ Date of last use: _____

TERTIARY Drug of Choice:

☐ None ☐ Alcohol ☐ Amphetamine ☐ Barbiturate ☐ Benzodiazepine ☐ Ecstasy ☐ Cocaine
☐ Fentanyl ☐ Hallucinogens ☐ Heroin ☐ Inhalants ☐ Marijuana ☐ Methamphetamine ☐ Opiates

How often have you used in the last 30 days: _____ Age of FIRST use: _____ Date of last use: _____

IV DRUG USE: ☐ Current IV drug user ☐ Former IV drug user ☐ Never

LEGAL STATUS:

Number of Arrests in your lifetime: _____

Number of Convictions: Misdemeanor: _____ Felony: _____

Are you currently on Probation or Parole? ☐ No ☐ Yes – Jurisdiction: _____

FAMILY/COLLATERAL CONTACTS:

Significant Other:

Name: _____ Phone: _____

Address: _____

Mother:

Name: _____ Phone: _____

Address: _____

Father:

Name: _____ Phone: _____

Address: _____

Emergency Contact:

Name: _____ Phone: _____

Address: _____

Relationship: _____

Email: _____

Participant Signature: _____ Date: _____

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TRANSPORTATION PLAN

In the interest of public safety, the Courts are duty-bound to ensure potential participants have a solid, verifiable transportation plan in place prior to induction. Therapeutic Courts are rigorous programs requiring participants to coordinate a complex schedule of appointments among multiple service providers in addition to regular court appearances. By completing this form, the participant is demonstrating his or her ability to engage in all aspects of the program with a safe, reliable, and legal mode of transportation.

Participant's Name: _____
Last Name First Name Middle Initial

Driver's License Status: ☐ Valid ☐ Suspended ☐ Revoked ☐ Restricted –

What restrictions: _____ ☐ Not Licensed – Explain: _____

Driver's License Number: _____

Physical Address: _____
Street Apt. #

_____
City State Zip Code

Participant's Employer: _____
Company Name – *Indicate if Self-Employed or Unemployed*

Employer Address: _____
Street

_____
City State Zip Code

Client Work Shift (Start-End Time):

Sunday: _____ Monday: _____ Tuesday: _____ Wednesday: _____

Thursday: _____ Friday: _____ Saturday: _____

What is the participant's primary form of transportation? Check all that apply. If other, please explain.

☐ Personal Vehicle* ☐ Other Drivers ☐ Public Transit ☐ Bicycle ☐ Scooter

☐ Other – Explain: _____

*Vehicle Make: _____ Vehicle Model: _____ License Plate No.: _____

*Vehicle Insurance Provider: _____ Policy #: _____ Expiration: _____

(Attach proof of insurance with form submission)

All the following are required for each person that does or will provide transport for the client now or in the future. Use additional sheets if necessary.

1. _____
   Last Name First Name Middle Initial

   Date of Birth: _____ Relationship to Client: _____

2. _____
   Last Name First Name Middle Initial

   Date of Birth: _____ Relationship to Client: _____

3. _____
   Last Name First Name Middle Initial

   Date of Birth: _____ Relationship to Client: _____

Attestation: I attest that all the information provided on this form to be true and accurate to the best of my knowledge at this time. I understand that if any element of the information provided changes, however consequential, I am to immediately notify 1.) the Court 2.) probation 3.) my drug/alcohol testing site, and 3.) my treatment provider(s). I further certify that any deviation from this transportation plan requires Court approval in advance, and that approval or denial decisions are made by the Court with the interest of public safety, program integrity, and rehabilitation efforts as the foremost factors.

Client Signature: _____ Date: _____

Referral Source Signature: _____ Date: _____