BENTON COUNTY DISTRICT COURT
MENTAL HEALTH COURT

7122 W. OKANOGAN BUILDING A, KENNEWICK, WA 99336, (509) 735-8476 EXTENSION 3353

Listed below are the basic requirements of Mental Health Court (MHC). You must review the program handbook for a complete list of requirements.

- You must attend all court dates. Court dates are **Wednesday mornings** as follows:
  - Phase 1 – weekly
  - Phase 2 – bi-weekly
  - Phases 3 and 4 – monthly
- You must attend all case management appointments. Case management appointments are scheduled as follows:
  - Phase 1 – weekly
  - Phase 2 – bi-weekly
  - Phases 3 and 4 – monthly
- You may not consume alcohol while in MHC
- You may not use marijuana or other street drugs while in MHC
- You must take all of your medications as prescribed
- You must submit to random pill counts to verify medication compliance
- You must submit to random drug testing (UAs, saliva testing)
- You are required to complete a <u>minimum</u> of 20 hours of community service
- You are required to set goals when you enter MHC and you must make continuous progress towards achieving your goals
- You must maintain sober housing while in MHC
- You must attend two counseling appointments per month
- You must see your medication prescriber regularly
- You must participate in any services to which you are referred – chemical dependency treatment, self-help meetings, pain management, etc.
- You must provide documentation of your attendance at all appointments/meetings
- List all clinics, doctors, counselors, hospitals, etc. that may have documentation of your mental illness. (Verify that all locations are listed on the attached Release of Information (ROI). <u>You must list on the ROI under "other" any locations that are not pre-printed.</u>) _____

_____

_____ _____ _____

Name Signature Date

Reviewed with: _____, Defense attorney

BENTON COUNTY DISTRICT COURT
MENTAL HEALTH COURT

AUTHORIZATION TO RELEASE AND EXCHANGE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security: _____

I request and authorize the following agencies:

- [X] Alliance Consistent Care (E. D. Information Exchange)
- [X] 8am-8pm Family Medicine
- [X] Benton County Corrections
- [X] Benton-Franklin Counties Crisis Response
- [X] Benton-Franklin Dept. of Human Svcs.
- [X] Catholic Family Services
- [X] Chaplaincy Behavioral Health
- [X] Comprehensive Mental Health
- [X] Correct Care Solutions (CCS)
- [X] Department of Corrections (WA State)
- [X] Department of Social and Health Services
- [X] Domestic Violence Services
- [X] Eastern State Hospital
- [X] First Step Counseling
- [X] Grace Clinic
- [X] Greater Columbia Behavioral Health
- [X] Kadlec Health System
- [X] Lourdes Counseling Center
- [X] Lourdes Health Crisis
- [X] Lutheran Community Services
- [X] Mental Health Ombudsman
- [X] Nueva Esperanza Counseling
- [X] Our Lady of Lourdes
- [X] PACT
- [X] Somerset Counseling
- [X] Sunderland Family Trmt Svcs.
- [X] The Emmaus Center
- [X] Transitions
- [X] Tri-Cities Behavioral Health
- [X] Trios Health
- [X] WA State Prescription Monitoring Program
- [X] Merit Resource Services
- [X] Other: _____

to release and exchange healthcare information of the patient named above to the Benton County Mental Health Court Team:

Benton County District Court
Mental Health Court Staff
Benton County Public Defender/ Prosecutor
Benton County Probation

7122 W. Okanogan, Bldg A
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 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, Bldg A, Kennewick WA 99336. 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. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

- [X] Yes [ ] No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above.
- [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.

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES UPON THE END OF MENTAL HEALTH 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 DISTRICT COURT
MENTAL HEALTH COURT

Referral Form

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

Defendant Name – Last, First, Middle Initial

DOB Referral Date

Current Location (Inmate/Address)

Phone Number

Defense Attorney

Hearing: Pre-Trial ☐
Arraignment ☐
Show Cause ☐
Other: ☐ _____

	Check if DV
Case 1 _____	☐
Charge _____	
Case 2 _____	☐
Charge _____	
Case 3 _____	☐
Charge _____	
Case 4 _____	☐
Charge _____	

Reason(s) for the Referral: (Check all that apply)

- ☐ Possible suicide risk/danger to others
- ☐ Possible inability to care for self in or outside of the jail setting
- ☐ Possible evidence of mental disorder (e.g. psychosis, depression)
- ☐ Possible evidence of substance dependence/abuse **IN ADDITION TO** mental disorder
- ☐ Possible Felony Reduction (**Required**: Prosecutor must sign below)
- ☐ Other: _____

Brief summary of the presenting problem (**Required**): _____

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

Referring Party – Please Print Name

Prosecuting Attorney (Required for Felony Reduction)

Referring Party's Firm/Agency

Referring Party's Telephone Number

REQUIRED

*****PLEASE ATTACH A FULLY COMPLETED AND SIGNED RELEASE OF INFORMATION*****

Questions? Please contact Denise Kautzky, Mental Health Court Legal Assistant – (509) 735-8476 ext. 3353