BENTON COUNTY SUPERIOR COURT
ADULT DRUG COURT REFERRAL

Please fax referral packet to: (509) 736-2715

_____
Defendant Name

_____ _____
DOB Referral Date

_____
Current Location (Inmate/Address)

_____
Phone Number

_____
Defense Attorney

Checkif DV

Case 1_____

Charg e_____

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: _____

_____

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*****

Questions? Please contact the Adult Drug Court at (509) 736-3071 ext. 3229

Benton County Adult Drug Court

7122 W. Okanogan Place Ste A130, Kennewick, WA 99336, (509) 736-3071 ext. 3229

Listed below are the basic requirements of Adult Drug 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:

o Phase 1 – weekly
o Phase 2 – every 2 weeks
o Phase 3 – every 3 weeks
o Phase 4 – every 4 weeks
o Phase 3 – every 5 weeks
o Phase 4 – every 6 weeks

- Commit to 18 to 24 months of participation. (Exact length depends on your progress.)
- Be clean and sober. Do not use or have any illegal drugs, marijuana, or alcohol. Do not take any supplements without discussing with your case manager.
- Be on time for court and treatment.
- Complete community service hours as instructed.
- Go to treatment as required and do what your treatment provider tells you to do.
- Call the UA line every day 509-405-4595, (or go online to meritresources.reliatrax.net/pub/testingtimes). If your color is called, you must give a UA no later than 6:30 p.m. weekdays and 1:00 on weekends or holidays. You must also take a UA if anyone on the drug court team tells you to.
- Do not spend time with people who are not clean and sober. This means friends and family members who are actively using too. Do not go to headshops, bars, casinos, marijuana dispensaries, or any other high- risk environment.
- Do not have any kind of sexual relationship with anyone in Drug Court, including the waiting list.
- Do not lend, borrow, swap, or sell anything with another Drug Court participant without drug court's permission.
- Do not use or have any items used to consume drugs. These items are as follows, but not limited to needles, bongs, pipes and syringes.
- Tell drug court where you live. You must live in clean and sober housing.
- You, your house, your car, and anything you own and possess can be searched at any time.
- Dress appropriately for court and treatment. You may not wear shorts, tank tops, spaghetti straps. You cannot wear clothing the bears violent, racist, sexist, drug or alcohol related themes. If you are not dressed appropriately, you may be asked to go home and change.
- Pay costs and fees as ordered by the Drug Court.
- Do not leave Benton and Franklin Counties without permission from Drug Court. Live in Benton or Franklin County or within five miles of either county.
- If you speak with any Police Officer, you must tell them you are a participant in Drug Court, you must then tell Drug Court you had contact with the police officer.
- Sign a drug court participation agreement, which outlines your rights, benefits, and responsibilities.

_____	_____	_____
Name	Signature	Date

BENTON COUNTY SUPERIOR COURT
ADULT DRUG COURT

AUTHORIZATION TO RELEASE AND EXCHANGE HEALTHCARE INFORMATION

Patient's Name: _____ Date ofBirth:_____

Previous Name: _____ Social Security:_____

I request and authorize the following agencies:

[X]	Alliance Consistent Care (E. D. Information Exchange)	[X]	Greater Columbia Behavioral Health	[X]	SPARC Spokane
[X]	American Behavioral Health	[X]	Ideal Options	[X]	Sundown
[X]	Benton County Corrections	[X]	Imminent Health Care	[X]	Tranisitons
[X]	Benton-Franklin Counties Crisis Response	[X]	Kadlec Health System	[X]	Three Rivers Thearpy
[X]	Benton-Franklin Dept. of Human Svcs.	[X]	Lourdes Counseling Services	[X]	Tri-Cities Behavioral Health
[X]	Catholic Charities	[X]	Lourdes Health Crisis	[X]	Tri-Cities Community Health
[X]	Comprehensive Mental Health	[X]	Luthern Community Services	[X]	Tri-Cities Treatement Center
[X]	Correct Care Solutions (CCS)	[X]	Lynx Healthcare	[X]	Trios Health
[X]	Department of Corrections (WA State)	[X]	Mental Health Ombudsman	[X]	Triumph Treatment Center
[X]	Domestic Violence Services	[X]	MRJN Associates	[X]	WA Behavorial Health
[X]	Eastern State Hospital	[X]	Nueva Esperanza Counseling	[X]	WA Monitoring
[X]	First Step Counseling	[X]	Our Lady of Lourdes	[X]	Wa State Department of Children, etc.
[X]	Grace Clinic	[X]	Planned Parenthood	[X]	Other:_____
		[X]	Somerset Counseling	[X]	Other:_____

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

Benton County Superior Court
Adult Drug 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) 736-3057

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 puporse of (a) coordinating treatment services;(b) providing referral information; and (c) monitoring for compliance with a treatment program, including informaiton the court of diagnosisi, treatment issues, participation in treatment, attendance or non-attandance , progress, prognosis and completion of treatment. I understand I do not have to sign this authorization. I understaand 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

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 ADULT DRUG COURT JURISDICTION (this includes probationary period).
Note: This authorization may be photocopied for duplication as necessary for the use in gathering additional information.

Emergency Contact:

Name: _____ Phone: _____

Address: _____

Relationship: _____

Email: _____

Participant Signature: _____ Date: _____