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

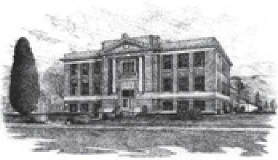
Listed below are the basic requirements of Adult Drug Court. You must review the program handbook for a complete list of requirements. You must attend regular court hearings and case management appointments.

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

Benton County Adult Drug Court
7122 W. Okanogan Place SteA130, Kennewick, WA 99336, (509)736-3071 ext. 3229

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: Check all that apply

Primary care doctor? ☐ No ☐ Yes - __________________ Last Exam: __________________
Current medical conditions? ☐ No ☐ Yes - __________________
Allergies? ☐ No ☐ Yes - __________________
Current medications? ☐ No ☐ Yes - __________________
Dental care? ☐ No ☐ Yes - __________________
Other healthcare not listed? ☐ No ☐ Yes - __________________

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 & Where: ____

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: _____________________________

Benton County Adult Drug Court

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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. Adult Drug Court is a rigorous program 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 –

☐ Restrictions - __________________________ ☐ Not Licensed – Explain: ________________________

Driver's License Number: ____

Physical Address: ____

Street Apt. #

____

City State ZipCode

Participant's Employer: ____

Company Name – *Indicate if Self-Employed or Unemployed*

Employer Address: ____

Street

____

City State ZipCode

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* ☐OtherDrivers ☐ 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

Dateof Birth: ________________ Relationship to Client: ________________________

2. ____

Last Name First Name Middle Initial

Dateof Birth: ________________ Relationship to Client: ________________________

3. ____

Last Name First Name Middle Initial

Dateof 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: ______________________