Treatment Court Referral

Outagamie County
Department of Criminal Justice Treatment Services

A single application will be considered for all specialty court programs within the Department of Criminal Justice Treatment Services (CJTS). We currently have the following programs:

- Drug and Alcohol Treatment Court (DATC) with separate tracks for OWI & Low Risk/High Need
- Veterans Treatment Court (VTC) with a separate track for Low Risk/High Need
- Mental Health Treatment Court (MHC)

Family Recovery Court (FRC) is within a separate Outagamie County Department and all referrals for this court should be directed to Dawn Schultz at HHSCYFFamilyCourt@Outagamie.org. We are unable to forward any referrals received for this treatment court.

Completed applications can be submitted the following ways:

- Emailed to CJTStreatmentcourts@outagamie.org
- Faxed to 920-968-4175
- Mailed or dropped off at Outagamie County CJTS, 320 S Walnut Street, Appleton WI 54911

APPLICANT INFORMATION

NAME	
TELEPHONE NUMBER	
EMAIL ADDRESS	
REFERRAL SOURCE	

DEMOGRAPHIC INFORMATION

DOB		LAST 4 OF SOCIAL SECURITY NUMBER			
RACE			ETHNICITY		
ADDRESS					
CITY		COUNTY		ZIP CODE	

Current Living Situation: ☐ Sober Living ☐ Homeless ☐ Own Home/Apartment ☐ With a friend/relative

LEGAL STATUS

☐ INCARCERATED ☐ ON BOND ☐ ON PROBATION AND/OR EXTENDED SUPERVISION

CURRENT PENDING CHARGES

IS THERE A VICTIM IN THIS MATTER? ☐ YES ☐ NO

VICTIM RELATIONSHIP TO THE DEFENDANT

HAVE YOU EVER PARTICIPATED IN A TREATMENT COURT BEFORE? ☐ YES ☐ NO

WHEN DID YOU PARTICIPATE?

WHAT COURT(S) DID YOU PARTICIPATE IN?

DO YOU HAVE ANY ASSAULTIVE CHARGES ON YOUR CRIMINAL HISTORY: ☐ YES ☐ NO

If yes, please list charges:

MILITARY

Have you ever served in the United States Military?

☐ Yes ☐ No

Do you have a copy of your DD214?

☐ Yes ☐ No

Service Start Date:

Service End Date:

Are you eligible for VA benefits/services?

☐ Yes ☐ No

Branch of Service:

☐ Air Force ☐ Coast Guard ☐ Navy

☐ Army ☐ Marines ☐ Reserves

Combat Deployment? ☐ Yes ☐ No

Location:

Current Military Status:

☐ Active ☐ General under Other than Honorable Conditions

☐ Honorable Discharge ☐ Dishonorable Discharge

☐ General under Honorable Conditions ☐ Bad Conduct Discharge

PHYSICAL HEALTH

Do you have any currently health issues? ☐ Yes ☐ No

Please describe:

Are you able to participate in our program with these conditions? ☐ Yes ☐ No

Do you have any physical limitations? ☐ Yes ☐ No

Please describe:

Are you able to participate in our program with these limitations? ☐ Yes ☐ No

Have you ever experienced a Traumatic Brain Injury (TBI)? ☐ Yes ☐ No

Please describe:

Do you have Medicaid coverage?	Do you have any other health insurance?
☐ Yes ☐ No	☐ Yes ☐ No

Are you currently taking ANY medications? ☐ Yes ☐ No

Please list all medications you are prescribed, including over the counter medications and herbal supplements:

MENTAL HEALTH

Have you ever been formally diagnosed with a mental health issue? ☐ Yes ☐ No

If yes, please describe:

Have you ever attended counseling, therapy, or have been hospitalized for a mental health issue? ☐ Yes ☐ No If yes, please described where and when:

Are you currently taking any medications for mental health issues? ☐ Yes ☐ No

If yes, please list all medications you are prescribed, including over the counter medications and herbal supplements:

SUBSTANCE ABUSE

Have you ever abused alcohol or other drugs? ☐ Yes ☐ No

When was your last use and what substance (alcohol, drugs or both)?

Check all substances you have used in your entire life:

☐ Alcohol	☐ Marijuana/THC	☐ Cocaine
☐ Ecstasy/MDMA	☐ Heroin	☐ PCP
☐ Fentanyl	☐ Inhalants	☐ Kratom
☐ Methamphetamine	☐ Amphetamine	☐ Crack Cocaine

☐ Synthetic Marijuana (Spice/K2/Delta-8) ☐ Benzodiazepine (Xanax, Ativan, Valium)

☐ Opiate/Opioids (Norco, Codeine, Morphine, OxyContin) ☐ Hallucinogens (Mushrooms/LSD)

☐ Other:

Are you currently attending treatment for substance use issues? If so, where:

ACKNOWLEDGEMENT:

I understand that this information is intended to be used for eligibility into one of the treatment courts. It does not guarantee my acceptance into the program. Furthermore, I understand that the demographic information contained on this form (including ethnicity and race) will be used for statistical reporting purposes only and will not affect my eligibility.

Applicant Signature & Date

WAIVER OF EX PARTE CONTACT WITH TREATMENT COURT JUDGE

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

Consent for the Release and Exchange of Information
OUTAGAMIE COUNTY – CRIMINAL JUSTICE TREATMENT SERVICES
320 S. WALNUT STREET, APPLETON, WI 54911
920.832.5160 – PHONE 920.968-4175 – FAX

Participant information:

Full Name: _____ Date of Birth: _____

Between:

Criminal Justice Treatment Services 320 S. Walnut Street, Appleton, WI 54911	**And**	Wisconsin Department of Justice (DOJ) Division of Law Enforcement Services

Purpose of the disclosure: The information collected will be used to support program monitoring, evaluation, and statistical analysis.

Information requesting to be released/disclosed/exchanged:

X Criminal/legal background (including adult and juvenile arrests, charges, convictions, etc.)	X Mental/behavioral health treatment/ history
X Dates (Date of birth, date of death, date of treatment and other services, etc.)	X Personally identifiable information (Name, Social Security Number, State Identification Number, etc.)
X Drug screen/test results	X Program involvement/progress/discharge
X Education information	X Substance use assessment/diagnosis
X Employment information	X Substance use treatment/history
X Medical information	X Other:_____
X Medications (prescribed)	X Other:_____
X Mental/behavioral health evaluation/ diagnosis	X Other:_____

Disclosure of this confidential information may be made only as necessary for, and pertinent to, my participation in this program. I understand that my alcohol and/or drug treatment records and mental health records are protected under both Wisconsin state statutes and the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Parts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. Recipients of the information may re-disclose such information only in connection with their official duties. I understand that I may revoke this consent, verbally or in writing, at any time except to the extent that action has been taken in reliance on it.

This consent is effective on the date signed below and ends 6 months after the date of my discharge from the program.

In signing this form, I am granting permission for these agencies to release, disclose, and exchange information outlined above that will be collected during the course of my participation in the program. To the extent allowed by law, information obtained during my participation in the program may continue to be accessed and disclosed for purposes of program monitoring, evaluation, and statistical analysis after expiration of this consent. No information produced as part of evaluating the program will be identifiable to me.

I understand that I am under no obligation to sign this form and that the organizations listed above whom I am authorizing to use and/or disclose my information may not condition my treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this form. However, participation in the program is conditioned upon signing the consent form. I understand I will no longer be eligible for the program if I either do not sign the consent or revoke the consent.

I understand I have the right to inspect or copy the health information I have authorized to be disclosed by this consent form. I understand that I have the right to inspect and receive a copy of the material to be disclosed as required under the Wisconsin Department of Health Services Administrative Code (DHS 92.05 and 92.06).

I understand that I will be provided a copy of the signed form, if I request one.

I understand the information that may be disclosed or exchanged may be only used by the above agencies for authorized governmental activities associated with my participation in the program. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal privacy standards.

I hereby authorize the disclosure and exchange of the information described above.

Date Signed: _____

Participant Name (Please print): _____

Participant Signature: _____

Date Signed: _____

Witness Name and Title (Please print): _____

Witness Signature: _____

Outagamie County Criminal Justice Treatment Services
Authorization for Release and Exchange of Health or Confidential Information

1. Individual Served Information (subject of the record)

Individual Served Name	Date of Birth
Street Address/City, State, Zip	Phone Number

2. I authorize Outagamie County Criminal Justice Treatment Services, 320 S. Walnut Street, Appleton, WI, 54911 to release and receive records and information TO/FROM:

Outagamie County:

☐ **Children, Youth, and Families (CYF)** ☐ **Economic Support (ES)** ☑ **Mental Health/AODA (MH)** ☐ **Youth and Family Services (YFS)**

Outside Provider(s):

Name of person/Health Care Provider/Agency/Attorney	Street Address/ City, State, Zip Code	Phone/Fax Number
Outagamie County Drug & Alcohol Treatment Court Team	320 S Walnut Street, Appleton WI 54911	
Outagamie County Mental Health Treatment Court Team	320 S Walnut Street, Appleton WI 54911	
Outagamie County Veterans Treatment Court Team	320 S Walnut Street, Appleton WI 54911	
N/A		

I authorize the above named agencies/individuals to communicate and exchange written and/or verbal information, if applicable. 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 that sub-units of HHS, which are subject to HIPAA, may exchange confidential information about me pursuant to this release.

3. INFORMATION TO BE RELEASED (individual served initial on line)

____ Diagnosis	____ Psychological Evaluations	____ Child Abuse/Neglect Reports
____ Treatment Care Plan	____ Guardianship Records	____ Intake/Initial Assessment
____ Discharge report	____ Progress Notes/Case Notes	____ Financial Information
____ Discuss Case Specifics	____ Residential Records	____ History and Physical
____ Education Records	____ Vocational Records	____ 504/IEP/IBP
____ Immunizations	____ X-Ray/Ultrasound Report	____ Test Results
____ Law Enforcement Records	____ Court Records	____ Laboratory Results
____ Pick up medications	____ Make/Check on appointments	

____ Other (Specify): _____

In compliance with Federal and Wisconsin Statutes, which require special permission to release otherwise privileged information, please release records including records received from other sources, pertaining to:

____ Mental Health/Behavioral	____ Developmental Disabilities
____ Sexually Transmitted Diseases	____ HIV/AIDS
____ Intoxicated Driver Assessment/Plan	____ Substance Use Disorder Assessment
____ Substance Use Disorder Progress Notes	____ Substance Use Disorder Treatment Plans
____ Substance Use Disorder Discharge Summary	____ Substance Use Disorder – Test Results

____Other (Specify): _____

4. Purpose for release: ☐ **Continuity of care** ☐ **Treatment** ☐ **Legal**

☐ **Other (Specify):** _____

5. Format of release (subject to applicable fees):

☐ Paper Copy (mail) ☐ Paper Copy (pickup)

☐ Fax ☐ Email (subject to disclosure) Email address_____

6. DURING THE TIME PERIOD OF: FROM _____/_____/_____ TO _____/_____/_____

7. EXPIRATION DATE: This authorization will expire on: **_____/_____/_____** or upon termination from Criminal Justice Treatment Services and/or treatment court.

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.

- **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 Criminal Justice Treatment Services, 320 S. Walnut Street, Appleton, Wisconsin, 54911.
  - **Right to Receive Copy of This Authorization.** I understand that if I agree to sign this authorization, a signed copy of the form may be available upon request.
  - **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. See section at bottom of page to withdraw authorization.
- **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 Criminal Justice Treatment Services will not be receiving any direct or indirect payment in connection with the use or disclosure of my health information.
- **Note to the Patient and Receiving Agency:** The information disclosed to you may contain records protected by Federal confidentiality rules (42 CFR 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 CFR Part 2. A general authorization for 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, understand the content of this authorization form, and am signing this consent voluntarily. I have a right to request a copy of this form.

Individual Served Signature Print Name Date

Parent/Legal Authority Signature (If individual served is a minor) Print Name Date

Individual Served is: ☐ Minor (Under 14) ☐ Incompetent ☐ Disabled

Legal Authority: ☐ Custodial Parent ☐ Authorized Legal Representative

☐ Legal Guardian ☐ Power of Attorney for Healthcare

WITHDRAW AUTHORIZATION

I hereby revoke all prior signed consents to release the information selected above to any entity, agencies, other providers, family members. I understand that by revoking this consent I may be immediately terminated from treatment court.

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