

32nd Judicial District

Mental Health Court

STEP ONE (1): Complete a Referral Form and tender it to Denise Staggs, Mental Health Court Director for the 32nd Judicial District.

STEP TWO (2): Complete the following application.

Application Information

Thank you for your interest in the 32nd Judicial District Mental Health Court Program. The attached application must be completed in its entirety by the applicant's defense attorney and must be submitted with a signed release of information. The 32nd Judicial District Mental Health Court has releases designed for the program which are HIPPA compliant.

Return the Application to:

To: Denise Staggs, Mental Health Court Coordinator, 32nd Judicial District, Hohenwald, TN 38462.

Incomplete applications may be returned to the attorney of record and could result in a delayed response from the Mental Health Court Care Coordinator. If you have questions, please feel free to call us at: (931) 231-8343.

I. Obligation of Referring Attorney

The referral form you have previously submitted will be held pending a completed application and receipt of any prior mental health records.

- To verify any current mental health diagnosis and medications, your client will need to sign the attached HIPPA compliant release of information (ROI). You will need to submit a copy of the ROI to:
 - The attention of medical staff at Centerstone
 - In addition to all other prior Mental Health Providers listed in the Referral Form on this application
 - If you are unaware of any prior or presently existing mental health treatment, you should request that the referral form and application be accepted for an assessment based upon described symptoms

Once you have received the records – including records from previous providers, they must be included with the application.

- Please be prepared to verify that there are no holds on your client from other jurisdictions.

- Please obtain a copy of your client's Criminal History (print out) from the Clerk's office or D.A.

What happens when I submit an application for a client?

- If application is complete and the most recent mental health diagnosis has been confirmed prior to submitting the application, the applicant's name and referral form will be submitted to the District Attorney by the Mental Health Court Coordinator to see if there is an objection toward a possible Mental Health assessment. If no present diagnosis, an assessment will take place. A Case Manager from the selected treatment provider will interview the client and work on a Care Coordination Plan.
- It typically takes three or four weeks to process a Mental Health Court Application, but can take longer based on the applicant's enhanced needs or failure to turn in a complete application.
- If the applicant is eligible to enter our judicially-supervised Mental Health Court program, the Attorney of Record and Mental Health Court Director will review the paperwork with the applicant at or prior to the next court date before the client can be entered into Mental Health Court with a plea to the outstanding charge.
- Applicants seeking to enter into the Mental Health Court who are in custody will be released for assessment purposes, if necessary, but will otherwise be assessed in jail.

To be considered for entry into the court:

- S/he must have a diagnosed serious mental illness. (This can include newly diagnosed while in custody.)
- A belief that the defendant will benefit from treatment for that diagnosis.
- S/he must have insight into their mental health, be willing to show initiative, and have a history of doing well in a structured environment.
- S/he must reside in the 32nd Judicial District.
- S/he must have been declared to be competent and sane after completed forensic evaluations (if ordered).
- S/he has an open criminal matter in the 32nd Judicial District Circuit Criminal Court (Participants can enter pre-trial and post-plea.) Defendants with successive violations of probation are eligible if all other conditions are met.
- S/he is not required to register on the Sex Offender Registry.*
- There must be a nexus, or link, between the individual's mental health and their criminal charge.
- The defendant must be a candidate for an alternative sentence.*
- Participation in the MHC is voluntary and there must be informed consent by the defendant.

*Please see Page 3 for more information regarding charges that can DISQUALIFY someone from Mental Health Court

Charges NOT eligible for Mental Health Court:

1. Class A Felony Cases
2. Non-Probatable Class B Felony Cases
 - a. TCA 40-35-303
3. Defendants Required to Register on the Sex Offender Registry (TCA 40-39-201)
4. Drug Related Charges without co-occurring mental illness
 - a. Manufacture/Deliver/Sale/Possess with Intent to Manufacture, Deliver, or Sell
 - i. TCA 39-17-417 (1)(2)(3)(4)
 - b. Sell/Deliver/Distribute Counterfeit Controlled Substances
 - i. TCA 39-17-423
 - c. Manufacture/Delivery/Sale or Possession of Methamphetamines
 - i. TCA 39-17-434
 - ii. Initiation of Process to Result in Manufacture of Methamphetamines
 1. TCA 39-17-435
 - d. Defendants Required to Register on the Drug Offender Registry
 - i. TCA 39-17-436
5. Commission or Attempted Commission of Terroristic Acts
6. Human Trafficking Related Charges
 - a. Offense of Human Trafficking
 - i. TCA 39-13-314
 - ii. TCA 39-13-308
 - b. Especially Aggravated Sexual Exploitation of a Minor
 - i. TCA 39-17-1005(a)(1)
 - c. Commercial Sex Acts
 - i. TCA 39-13-309
 - d. Promoting Prostitution
 - i. TCA 39-13-515
 - e. Solicitation of a Minor
 - i. TCA 39-13-528(a)
 - f. Promoting Prostitution of a Minor
 - i. TCA39-13-512
 - g. Soliciting Sexual Exploitation of a Minor by Electronic Means
 - i. TCA 39-13-529
7. Defendants with charges that resulted in a serious personal injury will be looked at on a case-by-case basis.

*Mental Health Court maintains the right to accept and/or deny individuals on a case-by-case basis.

* If a defendant is charged with a Class A or B Felony, there must be a written agreement from the District Attorney stating that the charge will be reduced to one that is eligible for alternative sentence and not listed on our disqualifying charges list.

Mental Health Court

Application to Participate in Mental Health Court

This application about the person who has been referred, must be completed in its entirety by the applicant's defense attorney.

Defense Attorney or Referring Attorney: _____

Email: _____ Phone #: _____

Defendant:

Name: _____ SSN (last four digits): _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____

Gender: Male Female | Race: _____ | Ethnicity: _____ Birthdate: _____

Emergency Contact Name: _____ Relation to Applicant: _____

Emergency Contact Number: _____ Email: _____

Criminal Justice Information

Next Court Date: _____ (attach Status Order) County: _____

Case #(s): _____

Current Charge(s) and brief description: _____

Has the applicant been in an alternative sentencing program before? Yes _____ No _____

If yes, which one? Drug Court Other _____

Is applicant in custody? Yes No Where? _____

If in custody, are they receiving psychotropic medications? Yes _____ No _____

Is the District Attorney in support of application? Yes _____ No _____

Does applicant have a pending violation of State Probation? Yes No

If yes, PPO name: _____

If past history of assault and/or sex offense, please list charge, date sentenced, and a brief synopsis of the original affidavit of complaint (or attach with application): _____

Is applicant on the Sex Offender Registry? Yes No If Yes, SOR PPO name: _____

Health History

Has the defendant been seen by a medical provider in the past 12 months? Yes No

If yes, who did s/he see? _____

Has defendant been diagnosed with any of the following, please check the box beside it:

Diabetes Asthma Traumatic Head Injury (TBI)

High Blood Pressure Heart Disease COPD

Epilepsy Stroke Other: _____

Hepatitis A, B and/or C HIV/AIDS

Has defendant been seen by a mental health provider in the last 12 months (including at Jail/CCA)? Yes No

Mental Health Diagnosis: _____ Confirmed By: _____

Current/Last Therapist: _____ Facility: _____

History of Substance Abuse: Yes No Age Substance First Used: _____

If yes, drugs of choice: Alcohol THC Cocaine Heroin Narcotics Meth Other: _____

Date Substance Last Used: _____

Has the defendant ever had treatment for an alcohol and/or drug addiction? Yes No

If yes, where and when? _____

Social History

Has the defendant ever experienced any of the following (Check all that apply):

Physical Abuse Sexual Abuse Emotional Abuse Verbal Abuse

Been witness to Domestic Violence Been witness to Homicide Other Trauma: _____

Education History: What is the highest level of education the defendant has achieved?

High School/GED Associate's Degree Bachelor's Degree Master/Doctoral Other: _____

Marital Status: Single Married Widowed Divorced Other: _____

Does the defendant have any dependent children? Yes No

If yes, please explain the custody/support system along with the names/ages of children: _____

Has the defendant been homeless within the past 6 months? Yes No

Does the defendant currently have insurance? Yes No If yes, name of insurance: _____

Has defendant had any insurance in the past? Yes No If yes, name of insurance: _____

Veteran w/Honorable Discharge: Yes No If yes, date _____ Branch of Service: _____

Years of Service: _____ Veteran Income: _____

Does defendant receive SSI/SSDI benefits? Yes No

If NO, has defendant applied and been denied SSI/SSDI in the past? Please explain: _____

If YES, how much does defendant receive per month? _____

Does the defendant have an independent payee? Yes No

If yes, who? _____

Work History

How long did defendant work at their last position? ≤ 1 yr. ≤ 5 yrs. ≤ 10 yrs. ≥ 10 Yrs.

Employer(s): _____

Client Attorney Check List

Please verify the following before submitting application:

_____ Obtain criminal history from Clerk's Office of D.A.

_____ Have you obtained proof of mental health diagnoses for client?

_____ Are there any holds from other jurisdictions for this client?

_____ Are there any child support holds?

Mental Health Court (MHC) Release of Confidential Information

_____/_____/_____
Name Date of Birth Social Security #

To: Medical Staff at Centerstone

I understand:

I do not have to sign a release. Signing this release is strictly voluntary. This release is limited to the information provided in my application for admission and ongoing participation in the Mental Health Court of the 32nd Judicial District.

I hereby authorize the 32nd Judicial District Mental Health Court Director, Denise Staggs, and Centerstone: To review my application to participate in Mental Health Court for the purposes of selecting a mental health treatment provider who will provide treatment services and assist me in obtaining essential resources which I may need to reside in the 32nd Judicial District when no longer incarcerated. I understand that Centerstone will be the Mental Health Treatment Provider for my management plan.

I understand that the MHC Team may need additional information about my mental or physical health and treatment history. I may be presented with additional releases of information which allow for my selected treatment provider as well as those who have provided treatment in the past to communicate regarding my treatment history and receive a historical overview of my treatment for review by the MHC Team. I understand this information may be needed in order for the MHC Team to offer treatment recommendations.

I understand that the MHC Director has signed a confidentiality statement which restricts the information needed to be discussed about my behavioral health history to MHC Team members only. I also understand that every organization which makes up the MHC Team has signed a Memorandum of Understanding which outlines their participation in the Mental Health Court.

Time period to be disclosed: _____ to _____. Unless I specify differently, this authorization will expire on the following date, event, or condition specified; from INTAKE to COMPLETION OF PROGRAM. If I do not consent to this time frame, this release authorization will expire in: 1 year.

The information may be shared: X in person X by phone X by fax X by mail.

I understand that the MHC Team and I may not be able to control what happens to my information once it has been released to the above-mentioned program representatives. I understand that information used or disclosed in accordance with this authorization may no longer be protected by federal law and could be disclosed by the receiving party. However, I also understand that federal or state law may restrict disclosure of HIV/AIDS information, genetic testing information and drug/alcohol diagnosis, history, treatment, referral or rehabilitation for substance abuse, therefore prohibiting the receiving party from re disclosure without my consent.

Second Party Release:

I authorize the 32nd Judicial District Mental Health Court Director to Release and/or Receive health, behavioral health and/or social service information on the individual named above to/from Centerstone: This release serves as a two-way or reciprocal release about my needs and the services I receive.

I understand and agree that this information will be used by the Mental Health Court and its agents, and I understand that by giving my authorization to release these type(s) of information, this information may no longer be protected by federal law and could be re-disclosed by the receiving party. However, I understand that federal and/or state law may restrict re-disclosure of HIV/AIDS information, genetic testing information, and drug/alcohol diagnosis, history, treatment, referral, or rehabilitation for substance

abuse (Federal confidentiality rules (42 CFR Part 2). A generic 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, therefore prohibiting the receiving party from re-disclosure without my consent. My consent to release includes.

Diagnosis; Treatment Plan; Progress Reports; Discharge Summary; Assessments; Evaluations; Prescribed Medications; Labs; Drug Test Results; Alcohol/Drug Treatment Plans

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and submit my revocation to my attorney, the District Attorney's office or the Public Defender's office. I understand the court has final authority over my case.

I may receive a copy of this authorization form. Electronic copies of this Authorization or any amendments hereto shall be binding upon the parties, and electronic reproduction of signatures appearing herein or on any reproduction shall be deemed to be original signatures. I have read or have been read the above statement and understand them as they apply to me.

Signature of Client/Legal Representative: _____ Date: _____

Signature of Witness: _____ Date: _____