Initial Arrest Date: _____ Contract/Plea Date: _____ GAID#: _____ Counselor: _____

Lookout Mountain Judicial Circuit Mental Health Court
Complete ENTIRE packet and e-mail to LookoutMountainMHC@gmail.com
Date:_____

Participant Information	
Name (First, Middle, Last, & Maiden):	DOB:
Social Security Number:	Gender:
Eye Color:	Hair Color:
Height:	Weight:
Ethnicity/Race:	Place of Birth (City & State):
Are you a U.S. citizen? Yes No	Preferred Language:
Preferred Religion:	Email Address:
Home Phone Number:	Cell Phone:
Sexual Orientation (Circle one): Homosexual Heterosexual Asexual Bisexual Other:_____	
Alias (other names or nick names):	
Driver's License State/Number:	Driver's License Issue Date: _____ Expiration Date:_____
Is your driver's license currently suspended? If yes, why?	Do you have a limited permit? Yes No
Residential Status	
Housing status (circle one): Own Rent Live with family Homeless Staying at a shelter Staying on someone's couch Rehab Facility or Supervised Housing Section 8 Housing Supported Apartments	
Address:	City/State/Zip:
How long have you lived at the address above?	
Education Information	
Name of High School attended & graduation year:	If you did not graduate high school, what is the highest grade level you completed? Year:
Do you have a GED? Yes or No. If yes, name of institution you received your GED and year you received your GED:	
Did you attend college/technical school? Yes or No	
Name of college or technical school:	Did you graduate? Yes or No. If yes, what year?

Initial Arrest Date: _____ Contract/Plea Date: _____ GAID#: _____ Counselor: _____

Relationship Status

Marital Status: Single Married Separated Divorced Serious Relationship Widowed

Date of marriage: _____ / Date of Separation: _____ / Date of Divorce: _____

Spouses Name: Address: Phone Number:

Dependents

How many children do you have?

Gender and DOB of children:
Child #1: _____
Child #2: _____
Child #3: _____

Do you have custody of your children: Yes or No. If no, who has custody?

Child #1: _____ Length of time? _____
Child #2: _____ Length of time? _____
Child #3: _____ Length of time? _____

Is there any open DFCS case involving your children: Yes or No. If yes, what county is your DFCS case?

What is your case mangers name? _____ What is your case number? _____

Employment/Income Information

Employment Status (circle one): Unemployed Employed Disabled Retired

Status start date (when did this status begin):

If employed, what is your employment type (circle one)? Full time Part time Volunteer Temporary

Name of employer:

What is your profession/ current position?

How many hours per week do you work?

What is your hourly rate or weekly pay?

Do you receive any of the following (circle all that apply): Food Stamps Unemployment TANF WIC

Social Security Disability VA Benefits

If receiving disability, when did you start receiving benefits and what are you receiving disability for?

How much do you receive each month in disability benefits?

If receiving Food Stamps, Unemployment, TANF, or WIC, when did you start receiving these benefits and how much do you receive each month?

Do you pay child support? Yes or No

If yes, what is your court ordered monthly obligation?

Initial Arrest Date: _____ Contract/Plea Date: _____ GAID#: _____ Counselor: _____

If yes, are you behind on child support payments? If so, how much?	
Do you receive child support? Yes or No. If yes, how much do you receive a month?	
Military Information	
Have you ever served in the Armed Forces? Yes No	Branch of service?
Enlistment date:	Discharge date:
Highest rank received:	Discharge type:
MOS/Job Assignment:	Total deployments:
Discharge reason:	Combat exposure? Yes No
Are you eligible for VA benefits? Yes No Unsure	Conflict Type:
Do you receive service connected benefits from the VA? Yes No	
What percentage of disability do you receive?	
Have you experienced any of the following (circle all that apply)? PTSD Sexual Trauma IED Exposure Traumatic Brain Injury	
List any medals/awards you received:	
Medical Information	
Have you ever been or are you currently receiving treatment for mental health issues? Yes No	
If yes, where?	
List any mental health diagnosis that you have received from a doctor:	
List any medications you are currently taking:	
Name of prescribing doctor:	
How long have you been taking these medications?	
Are you currently pregnant? Yes No	
What is your first drug of choice?	Age of first use: Date of last use:
What is your second drug of choice?	Age of first use: Date of last use:
What is your third drug of choice?	Age of first use: Date of last use:
How often were you using your first drug choice? Daily Weekly Monthly Route: How often were you using your second drug choice? Daily Weekly Monthly Route: How often were you using your first third choice? Daily Weekly Monthly Route:	
Have you ever experienced any of the following (circle all that apply): Tremors, Delirium, Overdose, Blackouts, Intravenous (IV) Use	
Does anyone in your family abuse drugs or alcohol? Yes No	

Initial Arrest Date: _____ Contract/Plea Date: _____ GAID#: _____ Counselor: _____

How many times have you been in treatment for substance use prior to this program?

What kind of treatment (circle all that apply)? Inpatient Outpatient Rehab

Dates of treatment?

How long was that treatment?

Legal Information

Are you currently on misdemeanor probation? Yes or No. If yes, answer the following:

What county are on probation in? _____ Probation Officer's Name: _____

What are the charges? _____

When were you placed on probation? _____ When does your probation end? _____

What are the conditions of your probation? _____

_____

Are you compliant? Yes or No

Are you currently on felony probation in another county? Yes or No

If yes, what's your Officer's Name: _____

Do you have any pending charges? If yes, what is the offense and the county/state?

Are you currently required to use any of the following (circle all that apply): Interlock GPS Ankle Monitor SCRAM

Are you in need of resources? (Example: food, clothing, bus passes, job leads, child care etc.)

Lookout Mountain Judicial Circuit
Mental Health Court

AUTHORIZATION FOR RELEASE OF CRIMINAL HISTORY

I hereby authorize the Lookout Mountain Judicial Circuit Office of the District Attorney to receive any criminal history record information pertaining to me which may be in the files of any criminal justice agency of any state or any local criminal justice agency in the State of Georgia. I authorize the Office of the District Attorney to obtain, release, and distribute my Georgia Crime Information Center (GCIC) criminal history to the Lookout Mountain Judicial Circuit Mental Health Court staff and team members, including the Mental Health Court Coordinator, employees of Lookout Mountain Community Services, and any other Mental Health Court team member or designated representative thereof for the purpose of completing my assessment for participation in the Lookout Mountain Judicial Circuit Mental Health Court program. I understand that if I am accepted into the Mental Health Court, the program maintains the prerogative to receive and review my GCIC criminal history data for a minimum of five years following discharge.

_____ _____

Defendant Date

_____ _____

Social Security Number Date of Birth

Lookout Mountain Judicial Circuit
Mental Health Court

AUTHORIZATION FOR RELEASE TO VERIFY INFORMATION FROM THIRD PARTIES

I hereby authorize the LMJC Mental Health Court Coordinator and members of the Mental Health Court staff to contact, in any form, members of my household, employer, or any other persons necessary to verify or gain information for the purpose of determining my acceptance into or compliance with rules of the Lookout Mountain Mental Health Court. I further authorize the Mental Health Court Coordinator and members of the Mental Health Court Staff to disclose information about my case, charges, or participation in Mental Health Court to members of my household, employer, or any other persons necessary for the purpose of determining my acceptance into Mental Health Court or my compliance with Mental Health Court rules. This release shall extend from this date until I complete Mental Health Court or am terminated or voluntarily withdraw from the program.

_____ _____

Referral's Signature Date

_____ _____

Social Security Number Date of Birth

Lookout Mountain Judicial Circuit
Mental Health Court

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____, hereby consent to disclosure between

Initial: _____ the Lookout Mountain Judicial Circuit Mental Health Court Program, Treatment Providers, and Other Service Organizations of confidential information concerning substance use and treatment, medical/mental health status and treatment, and drug testing.

Initial: _____ I authorize any prison, detention center, county jail, or city jail in which I have been confined to release to the Lookout Mountain Judicial Circuit Mental Health Court all information in my records concerning my medical/mental health status and treatment, to include but not be limited to HIV (AIDS), Tuberculosis, and Hepatitis.

The purpose of and need for this disclosure is to allow the Lookout Mountain Judicial Circuit Mental Health Court to determine eligibility for the program and, if accepted, to supervise my treatment progress and maintain compliance. The extent of information to be disclosed includes my diagnosis, treatment plan, information about attendance at treatment sessions, cooperation with the treatment program, prognosis, and drug test results.

Initial: _____ I understand that if I am ineligible to participate in the Lookout Mountain Judicial Circuit Mental Health Court, my consent will be immediately revoked and NO confidential information collected for the purposes of assessment may be used against me.

Signature of Candidate: _____

Date: _____

DOB: _____

Witness: _____ Date: _____

Bridge Health **AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION**
P.O. Box 1027, LaFayette, GA 30728

Section A: Use or Disclosure of Health Information

☒ **By signing this Authorization, I authorize the use or disclosure of my individually-identifiable health information maintained by Bridge Health** _____ **to be disclosed to:**

Name: Lookout Mountain Judicial Circuit Mental Health Court
Print Name

Address: 104 Napier St. Lafayette Ga 30728
Print Address

Health information includes information I have given or information created by Bridge Health information may relate to my past, present or future physical or mental health or condition, the provision of my health care, or payment for my health care services.

I understand that Bridge Health is prohibited from disclosing information about treatment for alcohol or drug abuse without my specific written authorization unless a disclosure is otherwise authorized by federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR, Part 2).

☐ **By signing this Authorization, I authorize Bridge Health to obtain from:**

Name: _____
Print Name

Address: _____
Print Address

Section B: Scope and Use of Disclosure: ***Check One:***

Health information that may be used or disclosed through this Authorization is as follows:

☒ **All health information about me, including my clinical records created by Bridge Health. This information may include, if applicable:**

- Information pertaining to the identity, diagnosis, prognosis or treatment for alcohol or drug abuse maintained by a federally-assisted alcohol or drug abuse program; or;
- Information concerning the testing for HIV (Human Immune Virus) and/or treatment for AIDS (Acquired Immune Deficiency Syndrome) and any related conditions.

☐ **All health information about me as described in the preceding checkbox,** ***excluding*** **the following:**

_____

_____

☐ **Specific health information** ***including only*****:** _____

_____

_____

☐ **Other non-health information** ***including only:*** _____

_____

_____

Note: Describe the health information to be excluded or included in a specific and meaningful fashion.

Section C. Purpose of Use or Disclosure

The purpose(s) of this Authorization is (are): *Check one:*

☒ Specifically, the following purpose(s) Consideration for the Lookout Mountain Judicial Circuit Mental Health Court program. ; or

☐ The Client has initiated the request for information to be used or disclosed and the Client does not elect to disclose its purpose.
Note: This box may NOT be checked if the information to be used or disclosed pertains to alcohol or drug abuse identity, diagnosis, prognosis or treatment.

Section D: Authorization Expiration: One year from the date signed
(applicable event or date – mm/dd/yy) – Not to exceed one year.

Note: If an expiration event is used, the event must relate to the Consumer or the purpose of the use or disclosure.

Section E: Other Information of Importance

1. I understand that Bridge Health cannot guarantee that the Recipient will not redisclose my health information to a third party. The Recipient may not be subject to federal laws governing privacy of health information. However, if the disclosure consists of treatment information about a consumer in a federally-assisted alcohol or drug abuse program, the Recipient is prohibited under federal law from making any further disclosure of such information unless further disclosure is expressly permitted by written consent of the consumer or as otherwise permitted under federal law governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR, Part 2).

2. I understand that, except when I am (1) receiving research-related treatment or (2) receiving health care solely for the purpose of creating information for disclosure to a third party, I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment from Bridge Health.

3. I understand that I may revoke this Authorization in writing at any time, except that the revocation will not have any effect on any action taken by Bridge Health in reliance on this Authorization before written notice of revocation is received by Bridge Health. I further understand that I must provide any notice of revocation in writing to the Bridge Health. The address of the Privacy Officer is P.O. Box 1027, LaFayette, Georgia 30728.

4. *This paragraph is only applicable to certain Authorizations to disclose health information for marketing purposes:* I understand that Bridge Health may, directly or indirectly, receive remuneration from a third party in connection with the marketing activities undertaken by Bridge Health.

I have read and understand the terms of this Authorization. I have had an opportunity to ask questions about the use or disclosure of my health information.

Client's signature:_____ Date :_____

Print Client's full name: _____ DOB: _____

Signature of legal representative: _____ Date of signature:_____

Print name: _____Relationship of representative to client_____

Witness:_____Date_____ Witness:_____Date_____

Two Witnesses are required if consumer signs by a mark (x). One witness is required for all other signatures.

Bridge Health
P.O. Box 1027, LaFayette, GA 30728

SUBSTANCE ABUSE REDISCLOSURE NOTICE
PROHIBITION ON REDISCLOSURE OF CONFIDENTIAL INFORMATION

This notice accompanies a disclosure of information concerning a consumer in an alcohol or drug abuse treatment program, made to you with the consent of such consumer.

This information has been disclosed to you from records protected by federal confidentiality rules governing federally-assisted drug or alcohol abuse programs (42 C.F.R., 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 C.F.R., Part 2. A general authorization for the release of medical or other information is not sufficient for this purposes.

The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse consumer.