Appendix A

ALCOVY CIRCUIT RESOURCE COURT REFERRAL FORM

Date: _____

Full Name: _____ Date of Birth: _____

Social Security Number: _____ Gender: _____

Phone Number: _____ Email: _____

Address where you will live during the program: _____

City: _____State: _____ Zip: _____

County of Residence: _____

Please list all names and dates of birth for all individuals that will live or stay in the home below:

Name_____ Relationship_____ DOB: _____

Name_____ Relationship_____ DOB: _____

Name_____ Relationship_____ DOB: _____

Name_____ Relationship_____ DOB: _____

Name_____ Relationship_____ DOB: _____

Emergency Contact Name, Relationship, Phone, & Address: _____

_____

Emergency Contact Relationship: _____

Name & Phone Number of Person Completing this Form: _____

_____

DEMOGRAPHIC INFORMATION

Race/Ethnicity: _____ Primary Language: _____

Are you in a relationship? _____ Marital Status: _____

Name/DOB of Significant Other: _____

Do you have Transportation? ___ Children? _____

Ages of Children: _____ Custody & Residence of Children: _____

Prior Military Service (Include Branch & Dates): _____

Where did you go to school? _____What grade did you complete? _____

Employment Status (Full Time, Part Time, or Unemployed: _____

Employer Name & Location: _____

_____

CRIMINAL INFORMATION

Currently in Custody? _____ GASID#: _____

Currently on Probation? _____ County: _____

Arrest Date? _____ Current Charges: _____

Past Charges: _____

_____

MENTAL HEALTH/MEDICAL INFORMATION

Mental Health Diagnos(es): _____

Doctor or Facility Providing Diagnos(es): _____

Date of Most Recent Assessment: _____ Insurance/Medicaid/Uninsured: _____

Previous Mental Health Providers: _____

Previous Psychiatric Hospitalizations: _____

History of Substance Abuse/Addiction? _____ Drug(s) of Choice: _____

Previous Substance Abuse/Residential Treatment: _____

Current Medications

_____

_____

PLEASE RETURN THE COMPLETED FORM BY EMAIL OR FAX TO:

For Newton County Resource Court send to:
Email: judge3@co.newton.ga.us or Fax no.: 770-788-3770

For Walton County Resource Court send to:
Email: judge1@co.walton.ga.us or Fax no.: 770-266-1684

NEWTON COUNTY RESOURCE COURT

AUTHORIZATION FOR RELEASE OF INFORMATION TO RESOURCE COURT TEAM

By signing this release, I request and authorize View Point Health, the Newton County Public Defender's Office, the Newton County Sheriff's Office, the Covington Probation Office, and the Newton County Resource Court (NCRC) Coordinator to release to members of the NCRC Team any and all information related to my treatment for mental illness, substance abuse, drug testing, risk/needs assessment, and any other treatment and evaluation related to my screening and treatment for substance abuse for the purpose of evaluating my admission to, continued participation and advancement in, or termination from the NCRC.

All information I authorize to be released will be held strictly confidential and cannot be released by the NCRC to any other person other than members of the NCRC without my written consent. I understand that this authorization will remain in effect for three years after my graduation or termination from the NCRC.

I understand that unless otherwise limited by state or federal regulation, and except to the extent that action has been taken which was based on my consent, I may withdraw this consent at any time. I also understand that if I withdraw this consent, I will be terminated from the NCRC.

_____ _____

Signature of Applicant/Participant Date

_____ _____

Signature of Witness Date

USE THIS SPACE ONLY IF APPLICANT/PARTICIPANT WITHDRAWS CONSENT

_____ _____

Date Consent Revoked Signature of Applicant Participant

Participant's Name: _____
SSN#: _____

CONSENT FOR DISCLOSURE OF CONFIDENTIAL MENTAL HEALTH / SUBSTANCE ABUSE INFORMATION FOR USE AMONG NEWTON COUNTY RESOURCE COURT ADMINISTRATOR AND/OR PROVIDERS

I, _____, hereby consent to communication between
(Program Participant)
_____ and Newton County Resource Court.
(Relationship)

The purpose of this disclosure is to inform the Court of my eligibility and/or acceptability for mental health / substance abuse treatment services and my treatment attendance, prognosis, compliance and progress in accordance with the Newton County Resource Court's monitoring criteria.

Disclosure of this confidential information may be made as necessary for, and pertinent to hearings and/or reports concerning my current case.

Disclosures may also be made in the event of a medical emergency, crimes committed on the program premises, against program staff and to researchers / outside auditors. However, information will only be disclosed to researchers / outside auditors only if participants are not identified. _____ (**Client Initial**)

Disclosures will be made as the result of valid court order or relevant state law.

I understand that disclosures may be made of my HIV / AIDS status, or Hepatitis C status, however, such disclosures are only authorized as they pertain to my treatment and treatment options within the Newton County Resource Court program. _____ (**Client Initial**)

I understand that this consent will remain in effect and cannot be revoked by me until there has been a formal and effective termination of my involvement with the Newton County Resource Court program.
_____ (**Client Initial**)

I understand that any disclosure made is bound by Title 42 of the Code of Federal Regulations governing confidentiality of alcohol and drug abuse, and of mental health patient records, and the recipients of this information may disclose it only in connection with their official duties. This release is intended to comply with all laws of the State of Georgia and all provisions of HIPAA (45 CFR Parts 160, 164).
_____ (**Client Initial**)

_____ _____
Participant's Signature Date

_____ _____
Witness Date

AUTHORIZATION TO OBTAIN RECORDS
NEWTON COUNTY RESOURCE COURT (NCRC)

I, _____, Social Security Number, _____-_____-_____,

Date of Birth, _____, Case Number, _____, hereby request and authorize the Newton County Resource Court (NCRC) to obtain records from the following agencies:

INCLUDES ALL – DO NOT CIRCLE – ADD OTHER PARTIES NOT INCLUDED – MH, FAM. MD, ETC.

- Newton County Jail
- Newton County Health Department
- Newton Medical Center
- Newton County School System
- Social Security Administration
- Georgia Department of Labor
- GA Division of Behavioral Health and Developmental Disabilities
- ViewPoint Health Community Service Board
- Pine Woods Crisis Stabilization Unit (NEWTON)
- Newton County Department of Family and Children Services
- Georgia Regional Hospital
- Veterans Administration
- _____
- _____

The information so obtained will be used by the Newton County Resource Court (NCRC) for the purposes of (a) coordinating treatment services; (b) providing referral information; and (c) monitoring compliance with the treatment program, including informing the Court of diagnosis, treatment issues, participation in treatment, attendance or non-attendance, progress, prognosis and completion of treatment. The extent of the information to be disclosed is as follows:

- Dates of Hospitalization
- Discharge Summary
- Medical History
- Diagnosis
- Lab Reports
- Hepatitis History
- Psychiatric Evaluation
- Psychological Reports
- Social History
- Treatment Plan
- HIV/AIDS History
- Other: _____
- Progress / Activity Notes
- Nursing Assessment
- Correspondence
- Administrative/Legal Documents
- Tuberculosis History

By signing this Authorization I hereby waive any privileges with respect to any information released to NCRC which may include mental health, mental illness, mental retardation, and/or substance abuse information. I hereby consent to the release of information for court monitoring and case management services related to discharge planning and social services benefits. I further consent to the release information for primary care services related to diagnosis, treatment, evaluation and follow-up.

By signing below I hereby release the NCRC, its officers, agents and employees from any and all liabilities, damages, and claims which might arise from the release of information authorized above. I understand that this consent remains in effect **until three years following completion of the NCRC program** (completion, withdrawal or dismissal). I consent for my criminal history to be checked for five years following my completion, withdrawal or dismissal from NCRC for the purpose of follow-up, research, and program evaluation. I understand I may withdraw my consent at any time with written notification, but any information released prior to the withdrawal of consent remains authorized.

IMPORTANT: I understand that my alcohol and/or treatment records and behavior health treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability Act of 1996 (HIPPA), 45 C.F.R. Pts. 160 & 164, and cannot be disclosed without my written authorization unless otherwise provided for that regulation. HIV/AIDS information may not be redisclosed without my written authorization.

_____	_____	_____
Print Name	Signature of Defendant	Date
_____	_____	_____
Print Name	Signature of Attorney	Date