Initial Arrest Date: __________ Contract/Plea Date: ___________ GAID#: _____________ Counselor: ___________

Treatment Services

Wellness Accountability Court Participant Intake Form 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?

If yes, are you behind on child support payments? If so, how much?

Initial Arrest Date: __________ Contract/Plea Date: ___________ GAID#: _____________ Counselor: ___________

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

Initial Arrest Date: __________ Contract/Plea Date: ___________ GAID#: _____________ Counselor: ___________

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 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 purpôse 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

Initial: ____

I, ________________________, hereby consent to disclosure between 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: ________

Client Social Security Number ________________

Authorization for Release of Information

Client Name: ______________________________ Birth Date: ______________________

I hereby authorize______________________________ (or designee) of Health Connect America to:
Person or Position

Discuss with ____________ Send to ____________ Receive information from ____________

Name: ______________________ Phone: ______________ Address: ________________________

For the purpose of: ____

Information to be released:

☐ Medical evaluation
____ Psychiatric evaluation
____ Social history
____ Psychosocial
____ Discharge summary
____ Treatment/Case Summary
☐ Other: ______________

☐ Treatment Plan
____ Laboratory/ UDS results
____ Educational/Special Ed Records
____ Court Records
☐ Progress Notes
____ Assessment and Recommendations
☐ Other: ______________

____ Claims/Encounter Data
☐ Diagnostic Information
☐ Medication & Dosages
☐ Allergies
☐ Substance Use Hx Summary
☐ Trauma Hx Summary
☐ Employment Information
☐ Living Situation/Social supports

("HIV/AIDS Information" and "Substance Abuse information" must be separately and specifically listed on the "Other" line in order to release this information)

Type of Release/Expiration: (check the one that applies)

____ **One-time release**--the date the release expires is not to exceed **90 days** from date authorization is signed.

☐ **Ongoing Service Provision**--When a contracted or cooperating service provider requires the release of information for ongoing service provision not to exceed **one year**, or as the law or court order requires, from the date the authorization is signed.

Regarding the listed contact on this Authorization for Release of Information form, do you have any requests for restrictions with specific people or regarding specific information being released? (If yes, an additional forms will be completed (Communication Restrictions Form and/or Disclosure Restrictions Form)

☐ yes ☐ no Request for Communication Restrictions (with specific people)
☐ yes ☐ no Request for Disclosure Restrictions (regarding specific information)

This authorization may be revoked at any time upon written notification from the client and/or the parent/legal guardian (excluding information released prior to the revocation). Additionally, Health Connect America will not condition treatment, payment, enrollment or eligibility for benefits on the patient's consent, or the consequences for refusal to consent to the release of information.

This notice accompanies a disclosure of information concerning a patient in alcohol and drug abuse treatment, made to you with the consent of such patient. This information has been disclosed to you from records protected by Federal confidentiality rules. The Federal rules prohibits you from making any further disclosures of this information unless further disclosure is expressly permitted by 42 CFR. Part 2. A general authorization for the release of other information is not sufficient for this purpose. The federal rules restrict any use of this information to criminally investigate or prosecute a client or patient.

Individual's Printed Name: ______________________________ Date: __________
Individual's Signature: ______________________________
Parent's Printed Name: ______________________________ Date: __________
Parent Signature: ______________________________
Staff's Printed Name: ______________________________ Date: __________
Staff's Signature: ______________________________

*Clients have the right to request a copy of the Release of Information