6th Judicial District
Problem Solving Court Application Packet

IMPORTANT: PLEASE READ ENTIRE PACKET

Attorneys and Probation Officers:
If you are giving this application to a potential Problem Solving Court Participant, ensure that the applicant understands/reads the Multi-party/Agency Release of Information and initials and signs all designated areas of the packet.

Applicant:
The following Multi-Party/Agency Authorization for Release of Information gives the 6th Judicial District's Problem Solving Courts permission to share protected confidential information. Make sure you are aware of the potential disclosure of your information.

- **COMPLETE** this application packet **IN FULL** to avoid unnecessary delays in processing your application.
- Completed applications can 1)be turned into Room #307 Bannock County Courthouse 2) be turned into the mailbox for JoAnn Martinez in Room 220 Bannock County Courthouse 3)be turned into the County Courthouse for Oneida, Caribou, Franklin, Power, or Bear Lake and/or 4) can be mailed to:

JoAnn Martinez
Sixth District Manager, PSC
624 East Center Street #307
Pocatello, ID 83201

Problem Solving Court Description

District 6 Problem Solving Courts are intensely structured programs that promote recovery and self-sufficiency. These programs are phase based, requiring the participant to successfully complete the phases of the program. All phases are completed by developing competencies that promote recovery and self-sufficiency.

The Problem Solving Courts integrate treatment for mental health, substance use and criminogenic risks; using manualized, evidence based models that treat individual needs. There is an emphasis on employment, education and other productive activities. Intense supervision is a part of all the Problem Solving Courts and requires daily call-ins and frequent and random substance use testing which is directly observed by program staff.

The participant is required to attend all assigned treatment activities, comply with supervision, and attend status hearings on a regular basis with the presiding Judge. Participants will also pay a monthly Problem Solving Court fee in addition to their court fines and cost of supervision.

Once you are accepted into a Problem Solving Court you will receive a specific handbook regarding that programs outline as well as expected terms and conditions of supervision.

Make sure you complete the entire application:

- If a section *doesn't apply* then write 'D/N/A' in the margin
- If you *don't know* then write 'DK' in the margin.
- **→ or ← are used to signify locations that need your <u>initials</u> or <u>signature</u> to allow the PSCs to consider your application. Failure to do so may void your application.**

Failure to complete the entire application will delay your application process and may result in denial.

Applicant KEEP this page

SIXTH JUDICIAL DISTRICT PROBLEM SOLVING COURTS

Notice of Privacy Practices and Confidentiality of Alcohol and Drug Abuse Protected Health Information

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY!

Effective Date: ***March 13, 2008***

Health information which we receive and/or create about you, personally, in this program, relating to your past, present, or future health, treatment, or payment for health care services, is "protected health information" under the Federal law known as the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. Parts 160 and 164. The confidentiality of alcohol and drug abuse patient records maintained by this program is protected by another Federal law as well, commonly referred to as the Alcohol and Other Drug (AOD) Confidentiality Law, 42 C.F.R. Part 2. Generally, the program may not say to a person outside the program that you attend the program, or disclose any information identifying you as an alcohol or drug abuser, or use or disclose any other protected health information except in limited circumstances as permitted by Federal law. Your health information is further protected by any pertinent state law that is more protective or stringent than either of these two Federal laws.

This Notice describes how we protect personal health information (otherwise referred to as "protected health information") we have about you, and how we may use and disclose this information. This Notice also describes your rights with respect to protected health information and how you can exercise those rights.

Uses and disclosures that may be made of your health information:

• **Internal Communications:** Your protected health information will be used within our program that is between and among program staff who have a need for the information. Information may also be shared and among our program and the Department of Health and Welfare, and Business Psychology Associates and their contracted providers in connection with our duty to diagnose, treat, or refer you for substance abuse treatment. This means that your protected health information may be shared between or among personnel for treatment, payment or health care operation purposes. For example: Two or more providers within the program may consult with each other regarding your best course of treatment. The program and the County Clerk's office may share your protected health information with the Department of Health and Welfare and Business Psychology Associates and other billing sources in a billing effort to receive payment for health care services rendered to you. And/or, your protected health information may be discussed within the program about your treatment in connection with others in the program, in an effort to improve the overall quality of care provided by our program. Your protected health information will not be re-disclosed by program personnel and/or the Department of Health and Welfare, and Business Psychology Associates, except as is otherwise permitted herein.

• **Qualified Service Organizations and/or Business Associates:** Some or all of your protected health information may be subject to disclosure through contracts for services with qualified service organizations and/or business associates, outside of this program, that assist our program in providing health care. Examples of qualified service organizations and/or business associates include billing companies, data processing companies, or companies that provide administrative or specialty services. To protect your health information, we require these qualified service organizations and/or business associates to follow the same standards held by this program through terms detailed in a written agreement.

• **Medical Emergencies:** Your health information may be disclosed to medical personnel in a medical emergency, when there is immediate threat to the health of an individual, and when immediate medical intervention is required.

• **To Researchers:** Under certain circumstances, this office may use and disclose your protected health information for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one test or treatment to those who received another, for the same condition. All research projects, however, must be approved by an Institutional Review Board, or other privacy review board as permitted within the regulations, that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

• **To Auditors and Evaluators:** This program may disclose protected health information to regulatory agencies, funders, third-party payers, and peer review organizations that monitor alcohol and drug programs to ensure that the program is complying with regulatory mandates and is properly accounting for and disbursing funds received.

*Applicant **KEEP** this page*

• **Authorizing Court Order:** This program may disclose your protected health information pursuant to an authorizing court order. This is a unique kind of court order in which certain application procedures have been taken to protect your identity, and in which the court makes certain specific determinations as outlined in the Federal regulations and limits the scope of the disclosure.

• **Crime on Program Premises or Against Program Personnel:** This program may disclose a limited amount of protected health information to law enforcement when a patient commits or threatens to commit a crime on the program premises or against program personnel.

• **Reporting Suspected Child Abuse and Neglect:** This program will report suspected child abuse or neglect as mandated by state law.

• **As Required By Law:** This program will disclose protected health information as required by state law in a manner otherwise permitted by federal privacy and confidentiality regulations.

• **Appointment Reminders:** This program reserves the right to contact you, in a manner permitted by law, with appointment reminders or information about treatment alternatives and other health related benefits that may be appropriate to you.

• **Other Uses and Disclosure of Protected Health Information:** Other uses and disclosures of protected health information not covered by this notice will be made only with your written authorization or that of your legal representative. If you or your legal representative authorize us to use or disclose protected health information about you, you or your legal representative may revoke that authorization, at any time, except to the extent that we have already taken action relying on the authorization.

Your rights regarding protected health information we maintain about you:

• **Right to Inspect and Copy:** In most cases, you have the right to inspect and obtain a copy of the protected health information that we maintain about you. To inspect and copy your protected health information, you must submit your request in writing to this office. In order to receive a copy of your protected health information, you may be charged a fee for the photocopying, mailing, or other costs associated with your request. In some very limited circumstances we may, as authorized by law, deny your request to inspect and obtain a copy of your protected health information. You will be notified of a denial to any part or parts of your request. Some denials, by law, are reviewable, and you will be notified regarding the procedures for invoking a right to have a denial reviewed. Other denials, however, as set forth in the law, are not reviewable. Each request will be reviewed individually, and a response will be provided to you in accordance with the law.

• **Right to Amend Your Protected Health Information:** If you believe that your protected health information is incorrect or that an important part of it is missing, you have the right to ask us to amend your protected health information while it is kept by or for us. You must provide your request and your reason for the request in writing, and submit it to this office. We may deny your request if it is not in writing or does not include a reason that supports the request. In addition, we may deny your request if you ask us to amend protected health information that we believe:

- Is accurate and complete;
- Was not created by us, unless the person or entity that created the protected health information is no longer available to make the amendment;
- Is not part of the protected health information kept by or for us; or
- Is not part of the protected health information which you would be permitted to inspect and copy.

If your right to amend is denied, we will notify you of the denial and provide you with instructions on how you may exercise your right to submit a written statement disagreeing with the denial and/or how you may request that your request to amend and a copy of the denial be kept together with the protected health information at issue, and disclosed together with any further disclosures of the protected health information at issue.

• **Right to an Accounting of Disclosures:** You have the right to request an accounting or list of the disclosures that we have made of protected health information about you. This list will not include certain disclosures as set forth in the HIPAA regulations, including those made for treatment, payment, or health care operations within our program and/or between our program and the Bannock County Clerk's office, the administrative boards and committees of Sixth Judicial District Drug Court, the Department of Health and Welfare, Business Psychology Associates and their contracted providers, or made pursuant to your authorization or made directly to you. To request this list, you must submit your request in writing to this office. Your request must state the time period from which you want to receive a list of disclosures. The time period may not be longer than six years, and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request

within a 12-month period will be free. We may charge you for responding to any additional requests. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

• **Right to Request Restrictions:** You have the right to request a restriction or limitation on protected health information we are permitted to use or disclose about you for treatment, payment or health care operations within our program and/or between our program and the Bannock County Clerk's office, the administrative boards and committees of the Sixth Judicial District Drug Court, the Department of Health and Welfare, and Business Psychology Associates. While we will consider your request, **we are not required to agree to it.** If we do agree to it, we will comply with your request, except in emergency situations where your protected health information is needed to provide you with emergency treatment. We will not agree to restrictions on uses or disclosures that are legally required, or those which are legally permitted and which we reasonably believe to be in the best interest of your health.

• **Right to Request Confidential Communications:** You have the right to request that we communicate with you about protected health information in a certain manner or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to this office, and specify how or where you wish to be contacted. We will accommodate all reasonable requests.

• **Right to File a Complaint:** If you believe your privacy rights have been violated, you may file a complaint with this office or with the Secretary of the Department of Health and Human Services at:

OFFICE FOR CIVIL RIGHTS
Medical Privacy, Complaint Division
U.S. Department of Health and Human Services
200 Independence Avenue, SW, HHH Building, Room 509H
Washington, D. C. 20201
Telephone: 866-627-7748 - TTY: 886-788-4989 Email: www.hh.gov/ocr

You will not be penalized or otherwise retaliated against for filing a complaint**.** If you have questions as to how to file a complaint please contact us at the above address.

Our responsibilities:

This office is required to:

- Maintain the privacy of your protected health information;
- Provide you with this notice of our legal duties and privacy practices with respect to your protected health information; and,
- Abide by the terms of this Notice while it is in effect.

This office reserves the right to change the terms of this Notice at any time and to make a new Notice with provisions effective for all protected health information that we maintain. In the event that changes are made, this office will notify you of a revised Notice by mail at the current address provided on your medical file, or provide you with a notice during your next office visit at the current address provided on your medical file.

This notice will be posted where registration occurs at each counseling office location. You have a right to receive a copy of this notice, and all individuals receiving care will be given a hard copy.

6th Judicial District Problem Solving Court Tracking Log

☐Accepted ___/___/___ Name _____ Application Date ___/___/___ Denied ___/___/___ ☐

Failure to complete/sign/initial **all** of the packet sections will **delay** the process of the application.

Court you are applying for: (circle) **Felony Drug Court** **Vet Court** **DUI Court** **Family Treatment Court** **Mental Health Court** **Wood Court**

Date of Birth:	Age:	Social Security #		Highest Education Obtained:
Address:			**Current Location:**	Military Service: **Y / N**
City:		LSI-R: _____	__Personal Residence	Violent Felony Conviction: **Y / N**
State:	Zip:	Date: ___/___/___	__County Jail: _____	Sex Offense Conviction: **Y / N**
Phone: Home	Cell		__Other: _____	Open Child Protection Case: **Y / N**
County:	Current Case Number(s):		Crime(s):	
Judge:	P.O.:	Parole: **Y/N**	Prosecutor:	Attorney:

↓ *(for office use only)* ↓

EXPLANATION OF DENIAL FOR ALL PROBLEM SOLVING COURTS	ADDITIONAL COMMENTS:
Drug Court:	_____
DUI Court	_____
Family Treatment Court:	_____
Mental Health Court:	_____
Veterans Court:	_____
Wood Court:	_____

Application
6th Judicial District Problem Solving Court

Name: _____ Date: _____

Background Information

Race:
- ☐ White
- ☐ Black
- ☐ Native American
- ☐ Asian
- ☐ Other _____

Ethnicity:
- ☐ Puerto Rican
- ☐ Mexican
- ☐ Cuban
- ☐ Other Hispanic
- ☐ Non-hispanic

Health Insurance

☐ Private ☐ Medicaid

☐ VA ☐ None

Marital Status: *Please Circle one*: Never Married - Divorced - Separated - Living Together - Married - Widowed

Significant Other/Spouse:_____

Children

Name *(Last, First, Middle):* _____ In custody of defendant: Yes / No
DOB: _____ Age: _____

Name *(Last, First, Middle):* _____ In custody of defendant: Yes / No
DOB: _____ Age: _____

Name *(Last, First, Middle):* _____ In custody of defendant: Yes / No
DOB: _____ Age: _____

Name *(Last, First, Middle):* _____ In custody of defendant: Yes / No
DOB: _____ Age: _____

Name *(Last, First, Middle):* _____ In custody of defendant: Yes / No
DOB: _____ Age: _____

Military Service

Have you served in the United States Military: ☐ No ☐ Yes, If yes: Branch_____
Years of Service_____ Do you have a DD214 ☐ No ☐ Yes Service Connected Disability_____%

Criminal History (Please list past convictions)

_____
_____
_____
_____

_____

Application
6th Judicial District Problem Solving Court

Mental Health History (Current AND Previous)

Please List any/all prescription drugs you are currently or are supposed to be taking & the prescriber:

1)	2)	3)	4)
5)	6)	7)	8)

Have you been diagnosed with any mental illness? Y / N, if yes, please list diagnosis and physician:

Have you been diagnosed with a Traumatic Brain Injury or PTSD? Y / N, If yes please provide details:

Are you currently or are supposed to be taking any psychotropic medications? Y / N, If yes please list:

Have you had any psychiatric hospitalizations? Y / N, If yes please list:

Drug Use History

List in Preferential Order	First	Second	Third
Substance			
Route of Administration: *Oral, inhalation, injection*			
Frequency: *Less than 1x p/month; 1-3 x's p/month; 1-2 x's p/week; 3-5 x's p/week; Daily*			
Date last used			
Age at first use			
Cost per day			

Current / Previous Substance Abuse Treatment

Level of Treatment	Provider/Court/Location	Begin/End Dates	Successfully Completed
☐ Inpatient/Residential			Y / N
☐ Intense Outpatient			Y / N
☐ Outpatient			Y / N
☐ Individual			Y / N
☐ Problem Solving Court			Y / N
☐ Prison			Y / N
☐ TC			Y / N
☐ CAPP			Y / N
☐ SHARE Program			Y / N
☐ SHARE Aftercare			Y / N

Application
6th Judicial District Problem Solving Court

I acknowledge the understanding that I will be required to complete a substance use and/or mental health disorder screening. My prior criminal record, if any, will be reviewed to determine whether I am eligible to participate in a problem solving court. I will be required to complete a Level of Service Inventory-Revised (LSI-R) evaluation. My results of the substance use and/or mental health disorder screening / assessment will be reviewed by a problem solving court will be at the sole discretion of the specific problem solving court team. I may/will be required to receive a literacy and/or education evaluation. Certain problem solving courts will require a minimum level of literacy and education.

If accepted into a problem solving court, I agree to comply with the following conditions of admission:

(1) I will comply with all requirements contained in the participant handbook of the problem solving court of which I am accepted.

(2) I will sign a probation agreement with the appropriate probation department, and fully comply with all requirements of probation.

(3) I will authorize release of all treatment information to the problem solving court team which may include, but not be limited to, my attorney, the prosecuting attorney, the judge, treatment representatives, a representative of probation and parole, misdemeanor probation and other community partners. This information may be used by the team to determine my level of participation and compliance with the problem solving court or to modify my release conditions and/or to terminate probation. The information will not be used by the prosecuting attorney for the prosecution of any new crime.

(4) I will appear in court for all scheduled hearings.

(5) I understand that my probation may need to be extended in order to complete the program in accordance with Idaho Code 19-2601. I understand that any failure on my part to comply with problem solving court requirements may result in modification or revocation of my probation, including the imposition of sentence.

DATED this _____ day of _____, 20____

→ _____

Applicant's Signature

Application
6th Judicial District Problem Solving Court

Multi-Party/Agency Authorization for Release of Information

Legal Last Name	First Name	MI	Date of Birth	Other Names Used

I, _____ voluntarily authorize and specifically request the presiding judge, the prosecuting attorney/deputy attorney, public defender/other defense counsel, and any employee or agent of the Idaho Department of Corrections, Problem Solving Court Coordinators and Problem Solving Court Teams, County Probation Staff, the Idaho Department of Health and Welfare (IDHW), IDHW Child Supportive Services, Community Transitional and half-way housing representatives, Court Appointed Special Advocate (CASA), Community based mental health and substance abuse providers, National Alliance for the Mentally Ill (NAMI), Recovery Coaches, IDHW Child Protection Services, Peer Support specialists, Idaho Supreme Court, Victim's Advocates, Interns, law enforcement agencies, jail detention staff or other educational, vocational, medical or health care providers or agencies to release, use, disclose, receive, communicate to one another, or mutually exchange the following information or records about me:

All of my health care information, medical records, and laboratory/diagnostic tests, from all sources and any other information.

By placing my initials in the spaces below, I specifically understand that the following highly confidential information or records will be released, used, disclosed, received, mutually exchanged or communicated to, by , among, or between any person, entity, or agency named in this authorization:

→HIV / AIDS_____ →Mental Health_____ →Alcohol / Drug_____ →Genetic_____ →STD_____ →TB_____

Initial that you are aware the above areas may be released to the mentioned parties above. *Initial all items*.

I have read this information or had this information read to me and I acknowledge an understanding of the purpose for the release of information. I am signing this authorization of my own free will. I understand that this information will allow my treatment team to plan and coordinate services I need, to impose appropriate sanctions or rewards based on my behavior, to submit billings for services, to audit, evaluate, or conduct legitimate research about drug treatment services and effectiveness, and will also allow any person, entity, or agency named in this authorization to be actively involved in my case coordination, evaluation, treatment, planning, or legal proceedings. I further understand that some or all of this information will be discussed in open court, a public forum, where any person in the courtroom may hear the information. I hereby request and give my permission for an open exchange of information to, by, among, or between, the presiding judge, the prosecuting attorney/deputy attorney, public defender/other defense counsel, and any employee or agent of the Idaho Department of corrections, Problem Solving Court Coordinators and Problem Solving Court Teams, County Probation Staff, the Idaho Department of Health and Welfare, law enforcement agencies, jail detention staff or other educational, vocational, medical or health care providers or agencies.

I understand that this information may include material protected under federal regulations governing confidentiality of alcohol and drug abuse patient records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPPA), 45 CFR Parts 160 &164 and cannot be disclosed without my written consent, unless otherwise provided for in the regulations. I can revoke this authorization, in writing, at any time, except to the extent that action has been taken in reliance upon it and with the understanding that such revocation will end my participation in treatment, which may result in the imposition of criminal sanctions. Although HIPPA requires that consents be revocable, 42 C.F.R. § 2.35 provides that if I am mandated into treatment through the criminal justice system or I am under legal/court supervision/probation, this authorization will remain in effect and cannot be revoked by me until there has been a formal and effective final disposition of the case that mandated me into treatment. I also understand that if I do not comply with treatment, my non-compliance will be reported to the judge and the prosecuting attorney/deputy attorney. A photocopy or exact reproduction of this signed authorization shall have the same force and effect as the original.

Full Legal Signature of Client or Authorized Personal Representative →	Relationship to Client	Date
Name of Staff Person(PRINT)	Initializing Agency Name/Location	Date

PROHIBITION OF REDISCLOSURE: This information has been disclosed to you from records which may be protected by federal confidentiality rules (42 CFR Part 2). If the information is so protected, 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 information is NOT sufficient for this purpose. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Application
6th Judicial District Problem Solving Court

Compliance & Assurance Questionnaire

1. I have a clear understanding of my rights as a client and have been given the opportunity to discuss any of my concerns. _____ ←

2. I understand that signing this release of information is voluntary and not required._____ ←

3. I was given this release of information prior to beginning treatment services._____ ←

4. I have signed this agreement without fear, intimidation, and/or coercion.____ ←

5. I understand if I decide not to sign, which is my right, I can be removed from treatment and will be reported to the referring agency._____ ←

6. I have been given a summary of the confidentiality laws._____ ←

7. I understand any information regarding ongoing criminal activity on my part is not protected and can be reported._____ ←

8. For criminal justice clients, the termination of this release of information will occur at the time of my completion of court ordered probation and or parole period._____ ←

9. If I am unable to read or comprehend this document, the release of information was read and explained in a manner in which I understood._____ ←

10. I was provided a copy of the release of information after signing._____ ←

Sixth Judicial District Problem Solving Court
CLIENT RIGHTS

The Sixth Judicial District Problem Solving Court programs agree to protect your fundamental human, civil, constitutional and statutory rights.

Your Rights include but are not limited to the following:

a. The right to impartial access to treatment and services, regardless of race, creed, color, religion, gender, national origin, age or disability.
b. Respect for personal dignity in the provision of all care and treatment.
c. The right to humane services, regardless of the source of financial support.
d. The right to receive services within the least restrictive environment possible.
e. The right to an individualized service plan, based on assessment of current needs.
f. The right to participate in planning for treatment and recovery support services.
g. The right of the client to request Department of Health and Welfare staff to review the service plan or the services provided.

By signing below, I acknowledge that I have been informed of my rights as a Problem Solving Court client.

→ _____ _____

Client/Applicant's Signature Date

Financial Eligibility Form

We are required by law to keep information about you confidential. The information is not to be passed on to anyone else or to be used for any purpose other than to establish financial eligibility to access state funded services.

Client's Legal Name: _____
Client ID: _____
Provider Name: _____
Client Social Security Number: _____

Submission Type

☐ Initial

☐ Financial Eligibility Update

Date Completed

_____

ELIGIBILITY DETERMINATION

All dollar amounts should be for the prior month.

1. Do You Have Insurance? To include Medicare, Veteran's benefits or other third party insurance.	YES NO
2. Do You Have Medicaid? If yes, include Medicaid number here:_____	YES NO
3. Number of People in Residence: Number of all individuals related to you by blood or marriage living on the property, including applicant, excluding those adults whose income is not considered.	
4. Current Gross Income for Residence: When calculating the gross income of the family household, an adult residing with one or more parents, relatives or unrelated individuals shall constitute a separate family household as long as that adult is not claimed as a dependent of any parent, relative or unrelated individual for income tax purposes. Therefore, only that individual's income and the income of his or her spouse and dependent children (if residing in the same household) shall be considered when establishing the family unit for purposes of calculating his or her ability to pay consistent with IDAPA 16.07.01.	
5. Court-Ordered Obligations All financial payments which have been ordered by a court that may include victim's restitution, courts costs and fees, fines supervision costs, the drug court or mental health court fees, child support, and alimony.	
6. Dependent Support Amount paid for an individual that is dependent on his family's income for over fifty percent (50%) of his financial support; to include child support, elder care, and alimony.	
7. Child care payments necessary for employment	
8. Medical expenses Amount paid for insurance premiums, payments to doctors and hospitals, medication, physical therapy, and dental.	

9. Transportation: Amount paid for car payments, gas, insurance, and public transportation.	
10. Extraordinary rehabilitative expenses Those payments incurred as a result of the disability needs of the person receiving services. They include monthly costs for items including, but not limited to, wheelchairs, adaptive equipment, medication, treatment, or therapy which were not included in the medical payments deduction and the annual estimate of the cost of services.	
11. State and federal tax payments, including FICA	
12. Total deductions: (add lines 5 through 11)	$
13. Income Amount Used to Determine Eligibility: (Subtract line 12 from line 4)	$
14. Reimbursement Rate: (See reimbursement table)	%

CLIENT AFFIRMATION: I affirm that the statements made herein are true and correct to the best of my knowledge. I understand that any false statements or misstatements of material fact could result in disqualification and/or criminal or civil action. I understand that I may be asked to provide verification of my statements of income, statements of expenses and dependents.

Client Name and Signature:	**Staff Signature:**
Date:	**Parent or Guardian Signature:**

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

PRIVACY ACT AND PAPER WORK REDUCTION ACT INFORMATION: The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Act. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless is displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 2 minutes. This includes the time it will take to read the instructions, gather the necessary facts and fill out this form. The execution of this form does not authorize the release of information other than that specifically described below.

The information requested on this form is solicited under Title 38 U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164; 5 U.S.C. 552a; and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if the information including the last four of your Social Security Number (SSN) and Date of Birth (used to locate records for release) is not furnished completely and accurately, VA will be unable to comply with the request. The Veterans Health Administration may not condition treatment, payment, enrollment or eligibility on signing the authorization. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act system of records notices identified as 24VA10P2 "Patient Medical Record – VA", 08VA05 "Employee Medical File System Records (Title 38)-VA" and in accordance with the Notice of Privacy Practices. VA may also use this information to identify veterans and person claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

TO: DEPARTMENT OF VETERANS AFFAIRS *(Name and Address of VA Health Care Facility)*

LAST NAME- FIRST NAME- MIDDLE INITIAL	LAST 4 SSN	DATE OF BIRTH

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL, OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

Veterans Court staff including probation officers, jails, judge, attorneys, county service officer, and D6 treatment providers.

PURPOSE(S) OR NEED: Information is to be used by the individual for:

☒ TREATMENT ☒ BENEFITS ☒ LEGAL ☒ EMPLOYMENT ☐ OTHER *(Please specify)* _____

INFORMATION REQUESTED: Check applicable box(es) and state the extent or nature of information to be provided:

☒ HEALTH SUMMARY *(Prior 2 Years)*

☐ INPATIENT DISCHARGE SUMMARY *(Dates)*: _____

☒ PROGRESS NOTES:

- ☐ SPECIFIC CLINICS *(Name & Date Range)*: _____
- ☐ SPECIFIC PROVIDERS *(Name & Date Range)*: _____
- ☐ DATE RANGE: _____

☒ OPERATIVE/CLINICAL PROCEDURES *(Name & Date)*: _____

☒ LAB RESULTS:

- ☐ SPECIFIC TESTS *(Name & Date)*: _____
- ☐ DATE RANGE: _____

☒ RADIOLOGY REPORTS *(Name & Date)*: _____

☒ LIST OF ACTIVE MEDICATIONS: _____

☐ FLU VACCINATION *(Dose, Lot Number, Date & Location)*: _____

_____

☐ OTHER *(Describe)*: _____

LAST NAME- FIRST NAME- MIDDLE INITIAL	LAST 4 SSN	DATE OF BIRTH

SENSITIVE DIAGNOSES: REVIEW AND, IF APPROPRIATE, COMPLETE WHEN RELEASE IS FOR ANY PURPOSE OTHER THAN TREATMENT.

I request and authorize Department of Veterans Affairs to release the information pertaining to the condition(s) below for the non-treatment purpose(s) listed in this authorization.

☒ DRUG ABUSE ☒ ALCOHOLISM OR ALCOHOL ABUSE ☐ SICKLE CELL ANEMIA

☐ HUMAN IMMUNODEFICIENCY VIRUS *(HIV)*

I understand that information on these sensitive diagnoses may be released for treatment purposes without me checking the above boxes, and will be released even if the boxes are unchecked unless I indicate by checking the box below that I do not want this information released for this specific disclosure.

☐ **I do not want sensitive diagnoses released for treatment purposes under this specific authorization. I realize this does not impact other future requests unrelated to this authorization.**

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing records. Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

I understand that the VA health care provider's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions.

EXPIRATION: Without my express revocation, the authorization will automatically expire.

☐ AFTER ONE-TIME DISCLOSURE, IF ALL NEEDS ARE SATISFIED

☐ ON _____ *(enter a future date other than date signed by patient)*

☐ UNDER THE FOLLOWING CONDITION(S): completion of or expulsion from Veterans Treatment Court. two way communication.

PATIENT SIGNATURE *(Sign in ink)*	DATE *(mm/dd/yyyy)*
LEGAL REPRESENTATIVE SIGNATURE (*if applicable) (Sign in ink*)	DATE *(mm/dd/yyyy)*

PRINT NAME OF LEGAL REPRESENTATIVE	RELATIONSHIP TO PATIENT

FOR VA USE ONLY

TYPE AND EXTENT OF MATERIAL RELEASED

DATE RELEASED	RELEASED BY: