NORTHAMPTON COUNTY MENTAL HEALTH COURT
Court of Common Pleas
Third Judicial District
669 Washington Street
Easton, PA 18042

MENTAL HEALTH COURT PROGRAM APPLICATION

DEMOGRAPHIC INFORMATION

Applicant's Name:_____ OTN/Docket #:_____

Aliases (if any):_____ Charges:_____

Address:_____
(STREET) (CITY) (STATE) (ZIP)

United States Citizen: Y N Length of Residency in Northampton County:____ _____ Phone_____
(YES) (NO) (YEARS) (MONTHS)

Birthdate:_____/_____/_____ Birthplace:_____ Height:_____ Weight:_____

Name of Attorney, if applicable:_____ Attorney Phone_____

Sex:_____Race:_____ Hair Color:_____ Eye Color:_____ Eye Glasses: Y N

Social Security #: _____-_____-_____ Identifying Marks, Tattoos_____

DRIVING INFORMATION

Driver's License/State ID #:_____ Issuing State:_____ License Status: Valid Suspended
(CIRCLE ONE) (CIRCLE ONE)

Vehicle Make & Model:_____ Year:_____ Color:_____

FAMILY INFORMATION

Marital Status:_____ Number of Dependent Children:_____

Household Members/Family Resources (Please list name, age, relationship to you, and their address and/or phone number if different than your own):

_____

_____

_____

PRIOR CRIMINAL RECORD

Do you have a prior criminal record? Y N If "Yes," please list all prior offenses, including traffic offenses:

DATE	PLACE	CHARGE(S)	RESOLUTION
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you owe any restitution? Y N If "Yes," please state the total amount owed on all cases: $_____

EDUCATION, EMPLOYMENT and MILITARY SERVICE

Highest Level of Education Attained & Institution:_____

Present Employer:

_____
(NAME) (ADDRESS) (TELEPHONE NUMBER)

Previous Employer:

_____
(NAME) (ADDRESS) (TELEPHONE NUMBER)

Reason for Leaving Previous Employment:_____

Other Income Sources:_____

Health Insurance:_____

Military Service? Y N If "Yes," please indicate: _____ _____
(BRANCH) (DATES OF SERVICE)

_____ _____
(HIGHEST RANK ATTAINED) (NATURE OF DISCHARGE)

MENTAL HEALTH

Current Mental Health Diagnosis:_____

Current and/or Past Treating Doctors, Agencies or Therapists:

NAME ADDRESS/PHONE DATES OF TREATMENT

_____

_____

Please list your current medications and prescribing physician:

_____

_____

_____

DRUG & ALCOHOL HISTORY

Do you use illegal drugs and/or alcohol? Y N If "Yes," please list the substances used and frequency of use:

_____

_____

_____

VERIFICATION: I _____, being duly sworn according to law do depose and say that the facts set forth in the foregoing are true and correct to the best of my knowledge, information and belief and I acknowledge that any false statements contained herein are punishable pursuant to 18 Pa.C.S.A. §4904(b) relating to Unsworn Falsification to Authorities.

_____ _____
(SIGNATURE OF APPLICANT) (DATE)

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PRE-ADMISSION ACCEPTANCE OF MENTAL HEALTH COURT RULES AND WAIVER OF RIGHTS

I, _____, hereby acknowledge that I have freely and voluntarily applied to the Northampton County Mental Health diversion program. If I am admitted to the program, t is my intention to participate in and comply with all aspects of the program, and in furtherance of that intention, I hereby agree to the following:

1. I will report to my Specialized Probation Officer ("SPO") and my Mental Health Case Manager as instructed.

2. I will reside at the address provided to my SPO and maintain a valid telephone number, which I will also provide to my SPO. I will not move without prior approval from my SPO and I will advise my SPO as to any changes in my telephone number within twenty-four (24) hours.

3. I will abide by the rules of this program and I will abide by the laws of any jurisdiction where I am present. If I am arrested, questioned or stopped by law enforcement, I will advise my SPO within seventy-two (72) hours.

4. I agree to give my consent and authorization necessary for the Mental Health Court Team to obtain information necessary to my treatment and participation in the program.

5. I will attend all court dates as required and will arrive on time.

6. I will dress appropriately for all court appearances. If I have questions about appropriate attire, I will refer them to my SPO.

7. I will not leave the Commonwealth of Pennsylvania without first obtaining the permission of my SPO.

8. I will maintain employment and notify my SPO within seventy-two (72) hours if I lose my job. If I am not employed, I will seek employment unless unable to do so (as supported by documentation). If directed to attend employment counseling or educational programming, including GED classes, I agree to do so.

9. I will support my dependents.

10. I will not knowingly supply false information to my SPO or to any member of the Mental Health Court Team.

11. I will attend all appointments with my mental health treatment providers and I will take all medications as prescribed by my treating physicians. I will cooperate with my Mental Health Case Manager and my SPO in their efforts to determine my compliance with treatment and medications.

12. I will participate in the Mental Health Court diversion program as directed by the Mental Health Court Team. I understand that if I fail to satisfy the conditions of the program, I may be subject to sanctions, up to and including removal from the program.

13. If, at any point, I wish to withdraw from the program or if fail to comply with the requirements of the program and I am removed at the discretion of the Court, I understand that I may enter a guilty plea or I may seek a trial on my charges.

14. I understand that I must refrain from the use, unlawful possession or sale of controlled substances while I am enrolled in the program, and that I must refrain from the use of alcohol. I also understand that I must submit to random urinalysis as directed.

15. I understand that I cannot own or possess any firearm, deadly weapon or offensive weapon during the program.

16. I will refrain from any assaultive or threatening behavior toward myself or others.

17. I agree to abide by all directives of the Court not expressly set forth herein.

I acknowledge that I have read, or have had read to me, the foregoing conditions, rules, and regulations of my participation in the Mental Health Court diversion program. I fully understand these conditions and agree to abide by them. I also fully understand that failure to abide by these conditions may result in disciplinary action, up to and including removal from the program and the return of my case to the Criminal Court for prosecution.

_____ _____

Name Date

_____ _____

Witness Date

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MEDICAL/MENTAL HEALTH PROFESSIONAL'S CERTIFICATION OF MENTAL HEALTH DIAGNOSIS AND DECISION-MAKING ASSESSMENT

Applicant Name_____ Date of Birth ____/____/_____

Completing Medical Professional's Name_____

Professional's Address_____

Professional's Agency_____ Agency Telephone Number_____

Length of Clinical Relationship with Applicant _____

Applicant's Clinical Mental Health Diagnoses (specify disorder and DSM Code):

_____

_____

Please list any prescribed medications and dosages:

_____

_____

_____

Please list current physical and mental health services or treatment providers:

_____

_____

Decision-Making Assessment

The above named applicant is my patient or has been clinically evaluated by me, and it is my clinical judgment that the applicant is independently capable of making a knowing and voluntary decision to seek admission into and to participate in the Northampton County Mental Health Court program. By signing below, I _____ hereby certify that all of the information contained herein is true and accurate to the best of my knowledge, and that my findings are made in accordance with my clinical judgment.

_____ _____
Medical/Mental Health Professional's Signature Date

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RELEASE AND AUTHORIZATION

I, _____ do hereby authorize the Northampton County Mental Health Northampton County Adult Probation, and Northampton County Mental Health Division to communicate with and to disclose to the following treatment provider(s):

_____

_____

and to one another the following information relative to my participation in the Northampton County Mental Health Court:

_____ My treatment and court attendance records

_____ My medication regimen and compliance

_____ My diagnosis, prognosis, and progress reports setting forth my compliance with treatment

_____ Discharge Summary

_____ Other _____
(please specify)

The purpose of this disclosure is to inform the authorized entities and their agents of my attendance and progress in treatment. I understand that my treatment records are protected under state law at § 7111 of the Mental Health Procedures Act (50 P.S. § 7101 et seq.) and 55 Pa. Code § 5100.31 et seq., as well as federal regulations governing confidentiality of mental health patient records at 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 & 164. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. I further acknowledge that my continued participation in the Northampton County Mental Health Court is contingent upon the continued validity of this release. I further acknowledge that this consent will expire upon my voluntary or involuntary termination from this program or my successful completion of the same. I recognize that pursuant to prevailing law, my review hearings are held in an open and public courtroom. I further recognize that it is therefore possible that an observer could be made aware of my treatment and participation in the Northampton County Mental Health Court and I specifically consent to disclosure by such means. I acknowledge that I have been advised of my rights, I have received a copy of this consent, I have had the benefit of legal counsel and I am not under the influence of drugs or alcohol. I fully understand my rights and I am voluntarily signing this Release and Authorization.

Applicant Signature_____ Date _____

Witness Signature_____ Date _____

NORTHAMPTON COUNTY PROBLEM SOLVING COURT
MILITARY QUESTIONNAIRE

(to be completed by Mental Health and Drug Court applicants who have served in the Armed Forces)

Name_____ Docket #(s)_____

Branch of Service_____ Enlistment Date_____

Discharge Date_____ Discharge Reason_____

Military Rank_____ Combat Experience Y N

Criminal Convictions Prior to Military Service Y N

If "yes," please list_____

Military Incarceration Y N

If "yes," please list_____

Exposed to Military Sexual Trauma Y N

Other Military Trauma Y N

Suffering from Traumatic Brain Injury Incident to Service Y N

Eligible for VA Benefits Y N If "yes," Receiving VA Benefits Y N

Participating in VA Services Y N If "yes" please list_____

_____

_____

Additional Information_____

_____

_____

Signature_____ Date_____