Mental Health Court

Chattanooga | Hamilton County

Application Information

Thank you for your interest in Mental Health Court. The attached application must be completed in its entirety by the **applicant's defense attorney** and must be submitted with a signed release of information (attached)

To: Clare Edens, Navigator, Mental Health Court at The Edney Innovation Center, 1100 Market Street, Ste. 600, Chattanooga, TN 37402. *Or emailed to Claree@hamiltontn.gov*

Or put in the drop box located outside of Division III of Criminal Court,
Or at the drop box located outside of Courtroom IV in General Sessions Court

Incomplete applications may be returned to the attorney of record and could result in a delayed response from the Mental Health Court Care Coordination Team. If you have questions, please feel free to call us at: (423) 209-6195 or (423) 362-6070

Attorneys:

- To verify current mental health diagnosis and medications, your client will need to sign the attached HIPPA compliant release of information (ROI). You will need to submit a copy of the ROI to:
  - the attention of medical staff at Silverdale (fax: 423-892-9551)
  - and/or other Mental Health Providers listed in the Release including places of previous incarceration

Once you have received the records—including records from previous providers, *they must be included with the application.*

- Please contact either Fugitive at 423-209-7140 or R & D at CCA, 423-855-6118, to see if there are any holds on your client.
- Please obtain a copy of your client's Hamilton County Criminal History (CJUS print out) from the Clerk's office.

What happens when I submit an application for a client?

- If application is *complete* and the most recent mental health diagnosis has been confirmed prior to submitting the application, the applicant's name will be submitted to the District Attorney by the Mental Health Court Navigator. The application is copied and submitted to the Care Coordination Team. A Case Manager from the selected treatment provider will interview the client and work on a Care Coordination Plan.
- It typically takes *three weeks* to process a Mental Health Court Application, but can take longer based on the applicant's enhanced needs or failure to turn in a complete application.
- If the applicant is eligible to enter our judicially-supervised Mental Health Court program, the Attorney of Record and Mental Health Court Navigator will review the paperwork with the applicant at the next court date (typically a Thursday) *before the client can be entered into Mental Health Court.*
- Applicants entered into Mental Health Court who are in custody *will be released on a scheduled Tuesday*, and from then on will be transferred from our Mental Health Court Navigator to our Mental Health Court Case Manager for additional Case Management alongside their Mental Health Provider.

To be considered for entry into the court:

>S/he *must have* a diagnosed serious mental illness. [This can include newly diagnosed while in custody.]

> The defendant will benefit from treatment for that diagnosis.

> S/he *must have* insight into their mental health, be willing to show initiative, and have a history of doing well in a structured environment.

> S/he *must* reside in Hamilton County.

> S/he *must have* been declared to be competent and sane after completed forensic evaluations (if ordered).

> S/he has an open criminal matter in Hamilton County General Sessions Court or Hamilton County Criminal Court [Participants can enter pre-trial and post-plea.]

> S/he is not required to register on the Sex Offender Registry.*

> There *must* be a nexus, or link, between the individual's mental health and their criminal charge.

> The defendant must be a candidate for an alternative sentence.*

> Participation in the MHC is *voluntary* and there *must be informed consent* by the defendant.

*Please see Page 3 for more information regarding charges that *can* DISQUALIFY someone from Mental Health Court

Charges **NOT** Eligible for Mental Health Court:

1. Class A Felony Cases
2. Non-Probatable Class B Felony Cases
a. TCA 40-35-303
3. Defendants Required to Register on the Sex Offender Registry (TCA 40-39-201)
a. Standard Treatment for Sex Offenders
i. TCA 39-13-701
b. Community Supervision for Life
i. TCA 39-13-524
4. Drug Related Charges
a. Manufacture/Deliver/Sale/Possess with Intent to Manufacture, Deliver, or Sell
i. TCA 39-17-417 (1)(2)(3)(4)
b. Sell/Deliver/Distribute Counterfeit Controlled Substances
i. TCA 39-17-423
c. Manufacture/Delivery/Sale or Possession of Methamphetamines
i. TCA 39-17-434
ii. Initiation of Process to Result in Manufacture of Methamphetamine
1. TCA 39-17-435
d. Defendants Required to Register on the Drug Offender Registry
i. TCA 39-17-436
5. Commission or Attempted Commission of Terroristic Acts
6. Human Trafficking Related Charges
a. Offense of Human Trafficking
i. TCA 39-13-314
ii. TCA 39-13-308
b. Especially Aggravated Sexual Exploitation of a Minor
i. TCA 39-17-1005 (a)(1)
c. Commercial Sex Acts
i. TCA 39-13-309
d. Promoting Prostitution
i. TCA 39-13-515
e. Solicitation of a Minor
i. TCA 39-13-528 (a)
f. Promoting Prostitution of a Minor
i. TCA 39-13-512
g. Soliciting Sexual Exploitation of a Minor by Electronic Means
i. TCA 39-13-529
7. Defendants with charges that resulted in a *serious personal injury* will be looked at on a *case-by-case basis.*

* Mental Health Court maintains the right to accept and/or deny individuals on a case-by-case basis.
* If a defendant is charged with a Class A or B Felony, there must be a written agreement from the District Attorney stating that the charge will be reduced to one that is eligible for alternative sentence and not listed on our disqualifying charges list.
*If an individual is on either on or furthermore required to be on the Sex Offender Registry, please contact our office for information regarding our Client Assistance Program.

Application to Participate in Mental Health Court

This application must be completed in its entirety by the applicant's defense attorney.

Name: ____ SSN: _____________ Phone #:_______________
Address: ________________________________ City: _____________________ State: ________ Zip: ________________

Gender: Male Female Non-Binary Other | Race: _________ | Ethnicity: __________ | Birthdate: __________

Emergency Contact Name: ___________________________________ Relation to Applicant: ________________________ Emergency Contact Phone: ______________________________ Email: ____

Criminal Justice Information
Next Court Date: ________________
General Sessions or Criminal Court | Division: ____ Judge: ____________________ SPN: ________________

Case # (s): ____

Current Charge(s) and brief description: ____

Has the applicant been in an alternative sentencing program before? Yes_____ No______
If yes, which one? Drug Court House of Refuge Transformation Project Teen Challenge Other: _________
Is applicant in custody? Yes No Where? Hamilton County Jail / CoreCivic (Silverdale)
If in custody, are they receiving psychotropic medications? Yes_____ No________
District Attorney:__________________________________ *District Attorney in support of application? Yes____ No_____
Attorney: ____________________________________ Email: ____

Attorney Phone #:_______________
Forensic Evaluation: completed (date: ________________) not requested (reason: ____________________)
Does applicant have a pending violation of State Probation? Yes No
If Yes, PPO name: ____
If past history of assault and/ or sex offense, please list charge, date sentenced, and a brief synopsis of the original affidavit of complaint (or attach with application):

____

____

Is applicant on the Sex Offender Registry? Yes No *If Yes, SOR PPO name*: ____________________________

Health History
Have you been seen by a medical provider in the past 12 months? Yes No
If yes, who did you see?

____

If you have been diagnosed with any of the following, please check the box beside it:
Diabetes Asthma Traumatic Head Injury (TBI)
High Blood Pressure Heart Disease COPD
Epilepsy Stroke Other: ____________________
Hepatitis A, B, and/or C HIV/AIDS
Have you been seen by a mental health provider in the last 12 months (including at Jail/CCA)? Yes No
Mental Health Diagnosis: ________________________________ Confirmed By:

____

Current/Last Case Manager: ____________________________ Facility:

____

History of Substance Abuse: Yes No Age Substance First Used:

____

If yes, drugs of choice: Alcohol THC Cocaine Heroin Narcotics Meth Other: ____________
Date Substance Last Used: _____________________
Have you ever had treatment for an alcohol and/or drug addiction? Yes No
If yes, where and when?

____

Social History
Have you ever experienced any of the following (Check all that apply):
Physical Abuse Sexual Abuse Emotional Abuse Verbal Abuse
Been witness to Domestic Violence Been witness to homicide Other Trauma: _________________
Education History: What is the highest level of education you have achieved?
High School/GED Associate's Degree Bachelor's Degree Masters/Doctoral Other: ______________
Marital Status: Single Married Widowed Divorced Other:____________
Do you have any dependent children? Yes No
*If yes, please explain your custody/support system along with the names/ages of children:

____

____

____

Have you been homeless within the past 6 months? Yes No
Do you currently have Insurance: Yes No *If yes, name of insurance*:

____

Have you had any insurance in the past? Yes No *If yes, name of insurance*:

____

Veteran w/ Honorable Discharge: Yes No *If yes, date*: ________ Branch of service: ______________
Years of Service: __________________________ Veteran Income:

____

Do you receive SSI/ SSDI benefits? Yes No
If NO, have you applied and been denied SSI/ SSDI in the past? Please explain:

____

____

If YES, how much do you receive per month? ______________________
Do you have an independent payee? Yes No
If yes, who? _______________________________

Work History: How long did you work at your last position? ≤ 1 yr. ≤ 5 yrs. ≤ 10 yrs. ≥ 10 yrs.
Employer(s):

CLIENT ATTORNEY CHECK LIST

Please verify the following before submitting application:

______ Obtain CJUS printout of criminal history from Clerk's office.

______ Have you obtained proof of mental health diagnoses for client?

______ Are there any holds from other jurisdictions for this client?

______ **Are there any child support holds?**

Mental Health Court (MHC) Release for Confidential Information

_________________________________ ____/____/____ ______-______-______

Name Date of Birth Social Security #

I understand:

I do not have to sign a release. Signing this release is strictly voluntary. This release is limited to the information provided in my application for admission and ongoing participation in the Hamilton County Mental Health Court.

I hereby authorize the Hamilton County Felony and/or Misdemeanor Mental Health Court Care Coordination Team (hereafter referred to as MHC Team) whose members include representatives from:

AIM Center, CADAS/Oasis, Camelot, Centerstone, Cherokee Health Systems, CHI Memorial, Community Kitchen, Erlanger Health Care Systems, Hamilton County Corrections Department, Hamilton County District Attorney's Office, Hamilton County Jail, Hamilton County Jail-Silverdale Site, Hamilton County Public Defender's Office, Health Connect America, Helen Ross McNabb Center, Homeless Health Care, Johnson Mental Health Center/Volunteer Behavioral Health Care System, Love's Arm, Mental Health Cooperative, Moccasin Bend MHI, Parkridge Valley, Partnership: Centers for Families and Children, Tennessee Department of Child Services, Tennessee Department of Corrections, & US Department of Veteran's Affairs, Other:_________________________

To review my application to participate in mental health court for the purposes of selecting a mental health treatment provider who will provide treatment services and assist me in obtaining essential resources which I may need to live in Hamilton County when no longer incarcerated. I understand that I have a choice as to which Mental Health Provider I select for treatment.

I understand that the MHC Team may need additional information about my mental or physical health and treatment history. I may be presented with additional releases of information which allow for my selected treatment provider as well as those who have provided treatment in the past to communicate regarding my treatment history and receive a historical overview of my treatment for review by the MHC Team. I understand this information may be needed in order for the MHC Team to offer treatment recommendations.

I understand that each member of the MHC Team has signed a confidentiality statement which restricts the information needed to be discussed about my behavioral health history to MHC Team members only. I also understand that every organization which makes up the MHC Team has signed a Memorandum of Understanding which outlines their participation in the Hamilton County Mental Health Court.

Time period to be disclosed: __________ to ___________. Unless I specify differently, this authorization will expire on the following date, event, or condition specified; from INTAKE to COMPLETION OF PROGRAM. If I do not consent to this time frame, this release authorization will expire in: 60 days 90 days 180 days 1 year.

The information may be shared; _____in person _____by phone _____by fax _____by mail.

I understand that the MHC Team and I may not be able to control what happens to my information once it has been released to the above mentioned program representatives. I understand that information used or disclosed in accordance with this authorization may no longer be protected by federal law and could be disclosed by the receiving party. However, I also understand that federal or state law may restrict disclosure of HIV/AIDS information, genetic testing information and drug/alcohol diagnosis, history, treatment, referral or rehabilitation for substance abuse, therefore prohibiting the receiving party from re disclosure without my consent.

Second Party Release:

I authorize the Hamilton County Mental Health Court to Release Receive health and/or social service information on the individual named above to/from the SECOND PARTY as directed below: This release serves as a two-way or reciprocal release about my needs and the services I receive.

Name/Agency: ______________________________ Relationship: ______________ Phone: ____________________

Name/Agency: ______________________________ Relationship: ______________ Phone: ____________________

Name/Agency: ______________________________ Relationship: ______________ Phone: ____________________

Name/Agency: ______________________________ Relationship: ______________ Phone: ____________________

I understand and agree that this information will be used and/or disclosed if I place a check by the applicable space next to the *type of information*, and I understand that by giving my authorization to release these type(s) of information, this information *may no longer be protected by federal law and could be re-disclosed by the receiving party*. However, I understand that federal and/or state law may restrict re-disclosure of HIV/AIDS information, genetic testing information, and drug/alcohol diagnosis, history, treatment, referral, or rehabilitation for substance abuse (Federal confidentiality rules (42 CFR Part 2). A generic authorization for the release of medical or other information is *NOT* sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient, therefore prohibiting the receiving party from re-disclosure without my consent.

Diagnosis Treatment Plan Progress Reports Discharge Summary Assessments

Evaluations Prescribed Medications Labs Drug Test Results Alcohol/Drug Treatment Plans

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and submit my revocation to my attorney, the District Attorney's office or the Public Defender's office. I understand the court has final authority over my case.

I may receive a copy of this authorization form. Electronic copies of this Authorization or any amendments hereto shall be binding upon the parties, and electronic reproduction of signatures appearing herein or on any reproduction shall be deemed to be original signatures. I have read or have been read the above statement and understand them as they apply to me.

Signature of Client/Legal Representative: ____________________________________ Date: ________________

Signature of Witness: ____ Date: __________