WASHINGTON COUNTY VETERANS TREATMENT COURT

Application Packet

Please submit the completed application packet to the Washington County Veterans Treatment Court (VTC) Coordinator.

Fax: (503) 846-8612

Email: Julianne_east@washingtoncountyor.gov

In-person/Mail: Julie East-Sanborn, 150 N. First Ave, Suite 300, MS 40, Hillsboro, OR 97124

Please note that this application packet will be forwarded to all members of the VTC treatment team, including the Washington County District Attorney's Office.

Application Packet

1. Application (3 pages)
    - Defendant and attorney must sign on page 3
2. Department of Veterans Affairs (VA) Release of Information Instructions (1 page)
    - For defendant and attorney reference
3. VA Release of Information Form (2 pages)
    - Defendant must sign on page 2
4. VTC Consent Form (3 pages)
    - Defendant must print name on page 1, paragraph 1
    - Defendant must initial on page 1, paragraph 3
    - Defendant and witness must sign on page 3

Application Process

This is a rough outline of the VTC application and screening process. Please defer to the VTC Coordinator to specify the steps for a specific candidate.

1. Contact VTC Coordinator for initial screening.
2. Complete and return application packet to the VTC Coordinator.
3. VTC team will evaluate eligibility based on program criteria.
4. VA Veteran Justice Outreach Specialist and VTC Probation and Parole Officer will contact candidate to screen for clinical need and criminogenic risk/need.
5. VTC team will alert the candidate's defense attorney of admission determination.
6. Candidate's defense attorney will work with the VTC DDA to establish the terms and date of entrance into the program, if admitted.

Please note: Veterans Treatment Court participants must promote to Phase II in the program for consideration of any modifications to no contact orders.

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Please note that this application will be forwarded to all members of the VTC treatment team, including the Washington County District Attorney's Office.

Name:_____ **Date of Birth:** _____

Pronouns (she/her, he/him, they/them) _____ **Gender** (Woman, Man, Nonbinary)_____

Race: _____ **Hispanic Origin (Yes / No)** _____

Address:_____ **Phone #:** _____

Email:_____ **DL #:** _____

Aliases (if any):_____

Employment/school:_____ **Phone #:** _____

Attorney Name:_____ **Phone #:**_____

Attorney Email:_____ **Fax #:**_____

Case Number(s) / dates of arrest / charge(s)

_____ /_____/ _____

_____ /_____/ _____

_____ /_____/ _____

1. Does Defendant reside in Washington County?____Yes_____No (county of residence:_____)

2. Does Defendant have any other pending cases or charges?_____Yes _____No _____Unknown

If Yes, charges and jurisdictions: _____

3. Does Defendant have any outstanding holds or warrants from any other jurisdiction

(including immigration matters)? _____Yes _____No_____Unknown

If Yes, charges and jurisdictions: _____

4. Is Defendant currently on Community Supervision / Probation in any other jurisdiction?____Yes_____No

If Yes, jurisdiction and offense: _____

5. What branch of service did Defendant serve in? _____

6. What type of discharge did Defendant receive?_____

7. What were the dates of service? _____ **(Attach a copy of your DD214).**

8. What combat zone or other similar hazardous duty area was Defendant deployed to?

_____Date(s) of deployment: _____

_____Date(s) of deployment: _____

_____Date(s) of deployment: _____

7. Does the attorney grant consent for the Veterans Court Supervision Officer to meet with Defendant for assessment, referral(s), and explanation of the program prior to being accepted into the VTC?

_____Yes _____No

8. Has Defendant previously accessed VA healthcare in the past? _____Yes _____No_____Unknown

THIS SECTION (QUESTIONS 11 – 17) TO BE COMPLETED BY DEFENDANT.

9. Have you ever been diagnosed with a mental health disorder or struggle with mental health symptoms (e.g. depression, PTSD, anxiety)?_____Yes _____No

If yes, which one/s?_____

10. Are you currently (and prior to your arrest) receiving mental health treatment?_____Yes _____No

If yes, what treatment are you receiving (e.g. medications, therapy, etc.)? _____

_____

11. In the past year, have you struggled with substance and/or alcohol use?_____Yes _____No

If yes, what substance(s)?

- **Alcohol**
- **Marijuana (Cannabis, spice, pot, weed)**
- **Other Stimulants (e.g., amphetamine, methamphetamine, Dexedrine, Ritalin, Adderall, "speed", "crystal meth", "ice", "crank", etc.)**
- **Cocaine ("Crack")**
- **Hallucinogens (Peyote, "acid", LSD, Mushrooms)**
- **Inhalants**
- **Opiates or analgesics (Heroin, Morphine, Percocet, Demerol, Oxycontin, Fentanyl, etc.)**
- **Sedatives or Tranquilizers such as benzos (Valium, Xanax, Ativan) Ambien, "barbs" such as Phenobarbital, downers, etc.)**

12. In the 30 days *before* your arrest, how many times did you use:

Alcohol _____

Marijuana _____

Cocaine _____

Amphetamines _____

Opiates (e.g. Heroin, Morphine, Dilaudid, Demerol, OxyContin, "oxy", Codeine (Tylenol #2, 3, 4), Percocet, Vicodin, Fentanyl, etc.) _____

Other substance use (please write name) _____

13. What type of treatment do you think the Veterans Treatment Court Program can help you with?

14. Please describe what you hope to gain from the VTC program and what the Court can expect of you.

15. Please explain in your own words how you believe your experiences during military service contributed to the behavior resulting in the above case(s).

I am capable of understanding the requirements for the Veterans Treatment Court, and the requirements have been fully explained to me by my attorney.

Signature of Defendant	Date	Signature of Attorney	Date

For District Attorney Use Only

Reviewed By _____ **Date** _____ **SID #** _____

Approved _____ **Denied** _____ **Reason:** _____

Information regarding VA Release of Information for Records*

If you are a Veteran and are interested in the Washington County Veteran's Treatment Court Program, one of the first steps is to verify VA eligibility and treatment history and need. The VA is a participating member of the Washington County Veterans Treatment Court team. If you are interested and would like the VA to provide information to the Vet Court team to verify your eligibility and treatment history and need, you can give permission by completing the following Information of Release Form. By completing and signing the form, you are allowing the VA to provide information about your treatment need, history, and adherence. This includes treatment appointment attendance, medications, UA and other testing results, program status, diagnoses, and treatment plan.

Instructions for ROI

Page 1

- Please write the Veteran's name, last 4, and date of birth in the appropriate boxes.
- Underneath those boxes you will see a box entitled NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL, OR TITLE OF INDIVIDUAL TO WHO INFORMATION IS TO BE RELEASED (also on top of page 2). That box should be prefilled with the entire Vet court team.
- Next you will need to check the corresponding Purpose or Need box (usually legal).
- Next is the Description of Information Requested section. This is prefilled and checked as Other with the description of "Verbal and written communication about treatment need, history, and adherence. This includes, treatment/appointment attendance, medications, UA and other testing results, program status, diagnoses, and treatment plan.

Page 2

- On Page 2, again complete the Veteran's name, last 4, and date of birth in the appropriate boxes.
- Underneath that, there is a box with the heading "Sensitive Diagnoses". If you are wanting any information regarding Drug Abuse, Alcohol Abuse, Sickle Cell Anemia, and/or HIV, you will need to check the corresponding box. The Vet Court Team will be inquiring about drug and alcohol treatment and history so if you would like the VA to provide this information, you will need to check these boxes.
- Next, you see the Expiration part. There are 3 options here. You will see that there is additional information typed in the "Under the following condition" section. By checking here, it allows the information to be released while the Veteran is engaged in the Vet Court program. If the Veteran does not enter the program or completes the program, no additional information will be shared.
- Lastly, on page 2, the Veteran will need to sign under PATIENT SIGNATURE and date under DATE box.

*These instructions were created to provide more information to veterans who are completing a VA Form 10-5345 to apply for the Washington County Veterans Treatment Court program. These are not the official VA instructions and should not be publicly posted.

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 information needed 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 the provision of treatment, payment, enrollment in the VA Health Care Program, or eligibility for benefits on the signing of an authorization, except for research-related treatment where an authorization for the use or disclosure of individually-identifiable health information for such research is required. 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 24VA10A7 "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)*

Portland VA Health Care System
3710 SW U.S. Veterans Hospital Rd
Portland, OR 97239

LAST NAME- FIRST NAME- MIDDLE NAME	DATE OF BIRTH *(mm/dd/yyyy)*

PATIENT'S MAILING ADDRESS (*including City, State and Zip Code*)

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

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

☒ TREATMENT ☐ BENEFITS ☒ LEGAL ☐ EMPLOYMENT ☒ OTHER *(Please specify)* to coordinate care & legal requirements

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)*: Two-way verbal/written communications

LAST NAME- FIRST NAME- MIDDLE NAME	DATE OF BIRTH *(mm/dd/yyyy)*

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 *(select one of the following)*:

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

☐ ON *(mm/dd/yyyy)* _____ *(enter a future date other than date signed by patient)*

☒ UNDER THE FOLLOWING CONDITION(S): Valid until Veteran completes Veterans Treatment Court programs/court involvement/probation, revoked by Veteran, or 5 years from signature.

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 *(mm/dd/yyyy)*	RELEASED BY:

WASHINGTON COUNTY VETERANS TREATMENT COURT

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

Advisement: This notice describes how medical and drug and alcohol related information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

By signing this form, I, (_____), or my authorized representative, consent to and authorize the Washington County Veterans Treatment Court ("Program") and the following individuals and entities listed below to disclose my information and communicate with one another regarding my eligibility and/or acceptability for the Program, to monitor my progress in and compliance with substance abuse and/or mental health treatment services, and to monitor my compliance with Program requirements and directives. This includes sharing with each other my assessment results, diagnostic conclusions, prescribed medications, unprescribed substance use, screening results, referrals to treatment and other services, treatment attendance records, progress in treatment, compliance with treatment, and compliance with Program requirements and directives. My information may also be disclosed in connection with an audit or evaluation of the performance of the Program and to determine whether the Program is following best practices such as the Oregon Specialty Court Standards.

I understand that my alcohol, drug, and/or mental health treatment records are protected under applicable state and federal law and regulations including, without limitation, ORS 3.450, the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and 45 C.F.R. Parts 160 & 164.

This disclosure is not intended to apply to confidential legal communications I have with my lawyer, or with the defense counsel named below. I verify that I have read and understand this (initial here) _____.

□ Washington County Circuit Court

□ Program Coordinator

□Veteran Mentor Coordinator

□ Department of Veterans Affairs, Portland VA Healthcare System

□ Harris Velázquez Gibbens, Attorneys at Law

□ Washington County District Attorney's Office

□Washington County Community Corrections Department

□ Washington County Sheriff's Office

□ Washington County Aging, Disability and Veteran Services

□ Solutions Group NW

□ LCN Wellness

□ Cedar Counseling Center

□ The Salvation Army Veteran and Family Center (VFC)

I understand that I have no legal right to participate in the Program and that this consent is required in order to participate in this Program. This consent form is used to obtain information to assess my compliance and progress toward achieving the Program's objectives. The Program is separate from treatment programs and other services I may receive while in the Program.

I understand that my treatment provider may not condition treatment, payment, enrollment, or eligibility for the treatment provider's benefits on the provision of this consent.

If I sign this consent my information will be disclosed to the people or programs listed on this form. The information disclosed to an entity covered under the HIPAA Privacy Rules may only be redisclosed with my written authorization or under other provisions of the HIPAA Privacy Rules. Information disclosed pursuant to this authorization may no longer be protected by the HIPAA Privacy Rules if it is disclosed to people or programs that are not subject to the HIPAA Privacy Rules. For example, the judge and attorneys who receive the information are not subject to the HIPAA Privacy Rules. However, the other federal regulations that protect my information will continue to apply. If my information is disclosed to a person or entity not covered by the HIPAA Privacy Rules, that person or entity may only redisclose my records with my written authorization or under other provisions of the federal regulations.

Identifying information including treatment status and compliance with Program requirements may be disclosed in the normal course of court proceedings open to the public and recorded in court data information systems available to the public, and I hereby authorize such disclosure. I understand that it is possible that an observer could make the connection between specialty court participation and substance abuse and/or mental health treatment. I understand that information disclosed during court proceedings will no longer be protected by the HIPAA Privacy Rules.

I understand that my treatment records and other treatment related information cannot be used to investigate, initiate, substantiate criminal charges against me. However, federal laws and regulations do not protect information related to the commission of a crime, or any threat to commit a crime, while on Program premises or against Program personnel. Additionally, federal laws and regulations do not protect information related to suspected child abuse or neglect from being reported under state law to appropriate state or local authorities.

I understand that I may revoke this consent at any time. I understand that this consent agreement is a condition of the Program and if I revoke my consent I will be terminated from the Program. Revoking my consent will not affect any information that was previously disclosed.

This consent will expire upon my completion of, or separation from, the Program, or upon the determination that I am not entering the Program.

Any violation of federal law and regulations is a crime and suspected violations may be reported to the U.S. Attorney for Oregon (see https://www.justice.gov/usao-or/our-locations) or the Substance Abuse and Mental Health Services Administration (SAMHSA)(see https://www.samhsa.gov/about-us/contact-us). You may sign this Consent using either: (i) an original signature on a printed document; or (ii) an electronic signature. If using an electronic signature, you may electronically sign either by typing "s/" followed by your name (example: s/ John Doe) or by using electronic signature software that includes a Security Procedure (defined in ORS 84.004) designed to verify your electronic signature.

I have read and understand the contents of this consent. I fully understand my rights and I am signing this consent voluntarily. I understand that, by signing this consent form, I am authorizing disclosure of my protected health information, as outlined above, to the persons and/or entities listed on this form. I further understand that this consent will be in effect for the duration of time I am in the Program, or until the determination that I am not entering the Program. I am not under the influence of drugs or alcohol.

Printed Name: _____

Signature: _____ Date: _____

Witness Name: _____ Position: _____

Witness Signature: _____ Date: _____