

NORTHAMPTON COUNTY MENTAL HEALTH COURT

**Court of Common Pleas
Third Judicial District
669 Washington Street
Easton, PA 18042**

MENTAL HEALTH COURT PROGRAM APPLICATION

PLEASE SUBMIT THE COMPLETED APPLICATION TO THE OFFICE OF JUDGE SLETVOLD.

DEMOGRAPHIC INFORMATION

Arrestment Date (New Charges) ___/___/___

Applicant Name: _____ CP Docket #: _____

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

OWNED RENTED RESIDE WITH FAMILY OR FRIEND OTHER:

United States Citizen: Y N Length of Residency in Northampton County: _____ Phone _____
(YEARS) (MONTHS)

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

Name of Attorney, if applicable: _____ Attorney Email _____

Gender: M F Other Race: _____ Eye Color: _____ Hair Color: _____

Last 4 of 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: _____ Name of Significant Other: _____

Children: Y N Child Support Obligation? Y N Amount: _____ Current? Y N

Child's Name Gender Date of Birth

_____ Full Custody Shared Custody No Custody Terminated

_____ Full Custody Shared Custody No Custody Terminated

_____ Full Custody Shared Custody No Custody Terminated

_____ Full Custody Shared Custody No Custody Terminated

Family Resources (please list name, relationship, and address):

PRIOR CRIMINAL RECORD

Do you have a prior criminal record? Y N Prior Record Score, if known (counsel, please calculate): _____

If "Yes," please list all prior offenses, including traffic offenses (using additional paper as necessary):

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

EDUCATION AND EMPLOYMENT

Highest Level of Education Completed & Institution: _____

Employer: _____
(NAME) (ADDRESS)

Job Title: _____ FT PT SCHEDULE _____

If unemployed, please provide the following information about your most recent employer:

(NAME) (ADDRESS) DATES OF EMPLOYMENT

Income Sources other than Wages/Amount./Frequency _____

Health Insurance Provider: _____ Is this Public Health Insurance? Y N

HEALTH HISTORY

Medical Providers

PHYSICIAN NAME	ADDRESS	TELEPHONE NUMBER	SPECIALTY
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Health diagnoses, including mental health and substance use disorder diagnoses: _____

HEALTH CONDITION TREATMENT HISTORY (including inpatient and outpatient treatment, facility, dates, and indicate successful or unsuccessful completion if applicable):

FACILITY	INPATIENT OR OUTPATIENT	DATES	COMPLETED?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

MEDICATIONS

NAME	DOSAGE	FREQUENCY	PRESCRIBER

MEDICAL MARIJUANA CARD HOLDER? Y N

OTHER

IF YOU HAVE A SUBSTANCE USE DISORDER, PLEASE ANSWER THE FOLLOWING QUESTIONS:

Have you used Medication Assisted Treatment? Y N I DON'T KNOW If "yes," type: _____

If there is any other information that you believe is relevant to your application that you wish to share with the Mental Health Court Team, please summarize below:

VERIFICATION: I _____, hereby verify 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)

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

MENTAL HEALTH COURT RULES AND WAIVER OF RIGHTS

I, _____, hereby acknowledge that I have freely and voluntarily applied, and been accepted into the Northampton County Mental Health diversion program. It 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 any pending charges, and if I am in the program for a violation, a hearing will be held to dispose of the same.
14. I understand that I must refrain from the use, unlawful possession or sale of controlled substances while I am enrolled in the program. 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

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

**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 IV 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

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

APPLICANT RELEASE AND AUTHORIZATION

Attendant with my application in the Northampton County Mental Health Court, I, _____ do hereby authorize the Northampton County Mental Health Court Team to receive and review my application and any supporting material, including past treatment information that may be known or made available to the team by any source, to include:

_____ My treatment and attendance records

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

_____ Discharge Summary

By this Release and Authorization, I grant the Northampton County Mental Health Court team, identified as the Northampton County Adult Probation Department (Jennifer Dodwell or their designee), the Northampton County Pretrial Division (Donielle Schuler or their designee), Northampton County Mental Health (Amanda Deppa, Nicole Seiple or their designee), the Presiding Judge (Judge Jennifer Sletvold or their designee), the Problem Solving Court Coordinator (Stephanie Steward or their designee), the District Attorney's Office (Daniel Polanski or their designee), the Public Defender's Office (Rory Driscoble or their designee), the Northampton County Prison Mental Health Court Liaison (Christopher Williamson or their designee), (collectively "Authorized Agents") the following information relative to my request for admission to the Northampton County Mental Health Court:

I understand and agree that the sole purpose of the disclosure permitted by this Release and Authorization is to inform the Authorized Entities to review my application to the Northampton County Mental Health Court, and for the Presiding Judge to make a determination regarding said application to the Court. I understand that my treatment records are protected under state law at The Pennsylvania Drug and Alcohol Abuse Control Act (71 P.S. § 1690.101 et seq.) and 4 Pa. Code § 255.5, as well as by federal regulations governing confidentiality of alcohol and drug abuse 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 understand that this consent satisfies the requirements of 42 C.F.R. § 2.31 and 2.35. I also understand that I may revoke this Release and Authorization at any time except to the extent that action has been taken in reliance on it. I further acknowledge that if I am admitted to the Northampton County Mental Health Court program, I agree to execute a Release and Authorization involving the same "Authorized Agents," permitting them to obtain and share with one another my treatment and program information, and the same will be a requirement of my participation in the Northampton County Mental Health Court. I recognize that if I am admitted to the program, I will participate in regular review hearings which, pursuant to prevailing law, 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 understand that my participation in the program will be contingent upon my consent to the same. I acknowledge that I have been advised of my rights, I have been offered and refused a received a copy of this consent, I have had the benefit of legal counsel in reviewing this consent, I am not presently under the influence of any substance that would affect my judgment, I fully understand my rights, and I am voluntarily signing this Release and Authorization.

Applicant Signature _____ Date _____

Witness Signature _____ Date _____

THIS RELEASE EXPIRES UPON MY ADMISSION TO OR DENIAL FROM THE NORTHAMPTON COUNTY MENTAL HEALTH COURT.