WELD COUNTY ADULT TREATMENT COURT
REFERRAL INFORMATION

Please review the attached Adult Treatment Court contract and Authorization to Share Information.

Once your case has been set on the adult treatment court docket in Division 5, you must complete the following:
Sign the attached Authorization to Share Information.
Fill out information below.

Participant Name: ____________________ Date of Birth: ____________

Current Address: ____________________

Phone (primary): ____________________ Phone (alternate): ____________________

Date of Referral: ____________________ Date for Return to Adult Treatment Court: ____________________

Do you think an alcohol or drug treatment program would help you now? ☐ Yes ☐ No

Is alcohol or drug use affecting your life? ☐ Yes ☐ No

If you are in custody, where will you live if/when you are released from custody (need address and phone number)?____________________

Who is your support system? (Name & relationship)____________________

Do you have reliable transportation? ____________________

Are you employed? ☐ Yes ☐ No If so, where? ____________________

Last grade completed: ____________________ GED?____________________

Are you currently pregnant or think you might be pregnant? ☐ Yes ☐ No

	AGE FIRST USE	DATE OF LAST USE	HOW OFTEN YOU USE IT	METHOD OF USE
ALCOHOL				
MARIJUANA				
COCAINE				
METH				
SPEED				
ECSTACY				
OPIATES				
BENZOS				
ACID				
INHALANTS				
SPICE				

OTHER:_____________				

Have you ever gone to ☐AA/NA ☐Detox ☐Outpatient ☐Intensive Outpatient ☐Inpatient

Where did you attend counseling/treatment? ____

Did you successfully complete treatment? ☐ Yes ☐ No

Do you have and/or applied for Medical Marijuana card? ☐ Yes ☐ No

Check the term that best describes your health? ☐ Poor ☐ Fair ☐ Good

Do you have any medical problems that may prevent you from keeping or gaining employment?

☐ Yes ☐ No

List current health problems below.

PROBLEM/DIAGNOSIS	CURRENT MEDICATIONS	DOCTOR

Have you had counseling in the past for anything besides drug or alcohol use? ☐ Yes ☐ No

If so, for what? ____

Have you been diagnosed with any past mental health disorder? ☐ Yes ☐ No

Are you taking medication? ____

Have you ever thought about or tried suicide? ☐ Yes ☐ No

Did you ever experience abuse as a child? ☐ Yes ☐ No

Have you ever been charged with or convicted of a sex offense? ☐ Yes ☐ No

Have you ever been charged with or convicted of a domestic violence offense? ☐ Yes ☐ No

AGENCY/THERAPIST	CITY/STATE	FROM	TO	PURPOSE OF COUNSELING

Please take the referral sheet and signed Release of Information to: Heather Allen, Problem Solving Court Coordinator, Clerk's Office, Centennial Center, 915 10th Street Greeley, CO, or by email Heather.Allen2@judicial.state.co.us

☐ Small Claims ☐ County Court ☒ District Court ☐ Probate Court ☐ Juvenile Court ☐ Water Court WELD County, Colorado Court Address: 901 9th Avenue, Greeley, CO 80632	
THE PEOPLE OF THE STATE OF COLORADO v. ________	▲ COURT USE ONLY ▲
Attorney or Party Without Attorney: (Name & Address) Phone Number: FAX Number: E-mail: Atty. Reg. #:	Case Number: Div.: DG Ctrm: 5

ADULT TREATMENT COURT PARTICIPANT CONTRACT

The mission of the Weld County Adult Treatment Court is to integrate substance abuse treatment, mental health treatment, intensive supervision and judicial oversight to promote public safety and individual responsibility, to reduce crime, and to improve the quality of life for participants and their families.

_______ I understand that by entering into this Adult Treatment Court contract, I am bound by its terms.

_______ I understand that if I enter this program and fail to complete it, I may be barred from future participation.

_______ I understand that the validity of this contract is conditioned upon my eligibility for the Adult Treatment Court program. If at any time after the execution of this agreement and in any phase of the Adult Treatment Court program, it is discovered that I am, in fact, ineligible to participate in the program, I may be immediately terminated from the program and will result in the filing of a complaint to revoke probation.

_______ I understand that participation in the Adult Treatment Court involves a minimum time commitment of eighteen months.

_______ I agree to cooperate in an assessment/evaluation for planning and individualized treatment program adequate to my needs. I understand that my treatment plan may be modified by the treatment provider or Adult Treatment Court Team as circumstances arise, and I agree to comply with the requirements of such modifications.

_______ I understand that my probation officer is my primary contact person in the Adult Treatment Court. I will meet with my probation officer on a regular basis.

_______ I understand that participating in Adult Treatment Court requires me to be drug, marijuana and alcohol free at all times. I will abstain from the use of all illegal drugs, marijuana and alcohol as well as other use of addictive or mind altering substances not approved by the treatment team. I will not associate with people who use or possess illegal or non-prescription drugs, nor will I be present while drugs, marijuana or alcohol are being used by others.

_______ I understand that I will be tested for the presence of drugs in my system on a random basis according to procedures established by the Adult Treatment Court Team and/or treatment provider.

_______ I understand that by participating in the Adult Treatment Court program, I must disclose that I am in possession of a medical marijuana card and will sign a release. I understand I will not be able to use marijuana in any form while participating in this program.

_______ I understand that I may not use or possess medical marijuana. I also understand that I may not be present while medical marijuana is being used by others.

_______ I will inform all treating physicians that I am a recovering addict and may not take narcotic or addictive medications or drugs. If a treating physician wishes to treat me with narcotic or addictive medications or drugs, I must disclose this to my treatment provider and Probation Officer and get specific permission from the Adult Treatment Court Team to take such medication, unless it is an emergency situation.

_______ I agree to be responsible for what goes into my body that may affect drug test results. Before taking medication of any kind, I will check with the pharmacist to ensure that it is a non-narcotic, non-addictive and contains no alcohol. I will notify my treatment provider of any and all medications I take, prescribed or over the counter.

_______ I agree that I will not leave any treatment program without prior approval of my treatment provider and the Adult Treatment Court Team.

_______ I understand that my individual course of treatment may include residential treatment, education, and/or self improvement courses such as anger management, parenting or relationship counseling.

_______ As a condition of participation in this program, I agree to the search of my person, property, place of residence, vehicle or personal effects at any time with or without warrant, and with or without reasonable cause, when required by my probation officer, Adult Treatment Court Team and/or law enforcement.

_______ I understand I must complete a mental health evaluation and take all prescribed medications.

_______ I understand that sanctions may include time in custody, increased supervision, increased testing, jury box, community service and such other sanctions may be deemed appropriate by the Adult Treatment Court Team.

_______ I agree to sign any and all releases of information. I understand that any information obtained from this release will be kept apart from the Court file.

_______ I understand that my failure to successfully complete and graduate from the Adult Treatment Court Program will result in the filing of a complaint to revoke probation.

_______ I understand that any violation of Adult Treatment Court or violation of North Range Behavioral Health may result in termination from the program.

_______ I understand that if I am not in treatment or there are no treatment options for me, I will be terminated from Adult Treatment Court.

_______ I understand that while in the program I have a curfew that I must comply with. This curfew means I am in my own home during the restricted hours. In order to attend work or a pro-social activity during my restricted time I must receive approval from my Probation Officer.

_______ I understand that I am subject to all provisions of the handbook, Terms and Conditions of Probation and Treatment Contracts.

I have read the above contract and I understand what I have read. I am willing and voluntarily entering into this agreement with the Weld County Adult Treatment Court Program.

____
Defendant Date

____
Defendant's Attorney Date

____
District Attorney Date

APPROVED

____
District Court Judge Date

19th JUDICIAL DISTRICT PROBLEM SOLVING COURTS
(including DUI, FTC and Adult Treatment Court)
AUTHORIZATION TO SHARE INFORMATION

Print Name:____ DOB:______________

I authorize the following agencies to share, when necessary, confidential information concerning me:

19th Judicial District
19th Judicial District Probation Department
Weld County Justice Services
Weld County Sheriff's Office
Weld County Drug Task Force, consisting of: Weld County Sheriffs Office, City of Greely Police Department, and the City of Evans Police Department.
Weld County Department of Human Services,
Weld County District Attorney's Office
Colorado State Public Defender, Weld County
North Range Behavioral Health
Reyes Corporation, aka, Creative Counseling Services of Colorado, LLC
Geo Group Inc., formally B.I. Incorporated
Intervention

_Other:______________________________ ____

____________________________________ ____

The agencies identified above will share confidential information only when they need the information to manage or provide services to me. This authorization is valid for exchange of information related to past, present, and future services and in connection with my participation in the 19th Judicial District Problem Solving Courts. This authorization expires one year from the date I sign the form, when sharing of information is no longer needed to manage or provide services to me, or when I revoke this authorization *whichever is sooner.* If I am not accepted into the program, this authorization is automatically revoked.

The purpose of this form is to enable the 19th Judicial District's Problem Solving Court interagency team to make appropriate recommendations and to allow the agencies listed above to better serve me through coordinated service planning and delivery. Representatives of the above agencies may meet and share information regarding me at scheduled planning and review meetings. I understand this program is not available to persons who have not violated probation or been screened into the 19th Judicial District's Problem Solving Courts.

(Please show your agreement with each paragraph by writing your initials on the line)

____ I understand that this authorization complies with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA), 45 C.F.R. Parts 160 & 164. As such, the 19th Judicial District's Problem Solving Court participating treatment agencies may not condition treatment, payment, enrollment or eligibility for benefits on my signing this Authorization

____ I understand that the following types of information may be shared: information that identifies me; records which have information about disabilities, diagnoses, evaluations or treatment; drug or alcohol treatment information including diagnosis, urinalysis results, information about my attendance or lack of attendance at treatment sessions, my cooperation with the treatment program and prognosis; sex offender evaluation and treatment information; work, school and social reviews and histories; education records; plans about services or benefits; eligibility information, information on finances; placement history; medical, psychological or psychiatric history; information pertaining to drug, alcohol, or HIV related care; or legal history. This authorization covers all admissions and/or contacts with the above listed agencies and service providers. This authorization allows an exchange of this information between and among the agencies and service

providers listed above in connection with their official duties and as it relates to my participation in the 19th Judicial District's Problem Solving Courts. The communications may be verbal, written, by facsimile (FAX) or by telephone or e-mail.

____ I understand that the agencies or individuals may need to share information among themselves more than one time and/or with other persons working for the agencies or service providers. I specifically authorize the re-release of this confidential information.

____ I understand I will be given a copy of this form. A person may use a copy or facsimile (FAX) of this form in place of the original signed authorization form.

____ In accordance with federal law, I specifically authorize any alcohol or drug abuse program I have been enrolled in to provide information concerning my participation in the program to employees or agents of any of the above named persons or agencies. The above names persons are authorized to re-release this information to any person or employee or agent of the any of the ab0ve named agencies on a need-to-know basis.

______ I understand that my alcohol and/or drug treatment records are protected by federal law and regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2 and may also be protected by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that recipients of this information may re-disclose it only in connection with their official duties.

____ In accordance with the Family Educational Right and Privacy Act (20 U.S.C. 1232), I specifically authorize any educational institution I have attended or been enrolled in to provide educational records to employees or agents of any of the above named persons or agencies. The above named persons or agencies are authorized to re-release this information to any person or employee or agent of any of the above named agencies.

____ The 19th Judicial DUI Court and Adult Treatment Court are being studied to find out if it is an effective way to keep people out of jail and abstaining from substance use. I give my permission to allow the agencies and providers of services to share information with the researchers doing this study. I understand that all information will be treated confidentially. Information for this study may be gathered as long as three years. Any reports of this study will be summarized as group information and will not be linked to me personally.

____ I understand I may revoke this authorization at any time except for information already shared in reliance upon this authorization. From that time on, agencies and providers will not share information unless the law allows them to without my authorization.

By signing this Authorization Form, I agree that I have read and understand the information on this form. I understand that there is the potential for redisclosure by the recipient and that it may no longer be protected by the HIPAA Privacy Regulation.

______________________________ ______________________________

Signature and Date | Witness/Agency and Date

______________________________ ______________________________

Signature and Date of Revocation | Witness/Agency and Date

NOTICE TO RECIPIENT: This information has been disclosed to you from records protected by federal confidentiality rules (42CFR Part 2). 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 release is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute an alcohol or drug abuse patient.