5TH Judicial District – Intake Packet

Date: _____ **Name:** _____

DOB: _____ **Social Security #** _____

Address: _____ **City:**_____ **State:** _____ **Zip Code:**_____

Cell Phone: _____ **Message Phone:** _____ **email:** _____

Resident County: _____ **Your Case is in** _____ **County**

Height_____ **Weight**_____ **Hair Color**_____ **Eye Colo**r_____

Gender: Male ☐ **Female** ☐ **Veteran Status:** Yes ☐ No ☐ **Branch:**_____

Have you ever been adopted?: Yes ☐ No ☐

Race: American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐
Hawaiian/Pacific Islander ☐ Hispanic ☐ Not Declared ☐ White ☐

Ethnicity: Cuban☐ Mexican☐ Non-Hispanic☐ Other Hispanic☐ Puerto Rican☐ Not Declared☐

Marital Status: Now Married ☐ Divorced ☐ Living Together ☐ Separated ☐
Single Never Married ☐ Widowed ☐

Name of significant other: _____

Are you currently pregnant? Yes ☐ No ☐ If yes, due date? _____

List all children and date of birth.	In your custody?	Did you use while pregnant?	Living with:
1. _____	Yes or No	Yes or No	_____
2. _____	Yes or No	Yes or No	_____
3. _____	Yes or No	Yes or No	_____
4. _____	Yes or No	Yes or No	_____

Are you currently enrolled in school? No ☐ Part time ☐ Full time ☐

Highest grade completed_____ High School Diploma ☐ GED ☐

Are you currently employed? Yes ☐ No ☐ Hours per week you work? _____

Employer _____ Supervisor _____

Company Address _____ Phone: _____

Primary Doctor _____

Please list any medical conditions and current medications and provide copies of current prescriptions.

_____

Do you have any family members with chemical dependency problems? Yes ☐ No ☐

Have you had any previous drug and/or alcohol treatment? Yes ☐ No ☐ Date:_____

If yes, where? _____

In what setting did you receive treatment? Residential ☐ Intensive Outpatient ☐ Outpatient ☐
Aftercare ☐ Detox facility ☐

Outcome: Completed ☐ Did not complete ☐ Non-completion reason:_____

Drug Use History: Please complete the following information.

40. 1st Drug of Choice_____

41. Substance_____

42. Method of Use: _____

43. How often_____

44. Last Used Date_____/_____/_____
Month Day Year

45. Age at first use_____

46. Cost Per Day_____

40a. 2nd Drug of Choice_____

41a. Substance_____

42a. Method of Use_____

43a. How often_____

44a. Last Used Date_____/_____/_____
Month Day Year

45a. Age at first use_____

46a. Cost Per Day_____

40b. 3rd Drug of Choice_____

41b. Substance_____

42b. Method of Use_____

43b. How often_____

44b. Last Used Date_____/_____/_____
Month Day Year

45b. Age at first use_____

46b. Cost Per Day_____

40c. 4th Drug of Choice_____

41c. Substance_____

42c. Method of Use_____

43c. How often _____

44c. Last Used Date_____/_____/_____
Month Day Year

45c. Age at first use_____

46c. Cost Per Day_____

Have you ever been diagnosed with a mental illness? IE: Anxiety, Bipolar, Depression Yes ☐ No ☐

Please explain:_____

Do you have insurance or Medicaid? Yes ☐ No ☐ Medicaid Number_____

Other Insurance Co._____ Group #_____

Sentencing date if known_____

Names of two other people who will know where you are:

_____Phone #_____

_____Phone #_____

Name: _____ Date: _____

In Custody: Yes ☐ No ☐ Where: _____

LIST EVERYONE WHO WILL BE RESIDING WITH YOU.

THESE ARE THE ONLY ONES TO STAY THERE UNLESS PERMISSION IS GIVEN BY PROBATION AND PAROLE AND TREATMENT COURT COORDINATOR.

NAME	RELATIONSHIP TO YOU	THEIR STANDING WITH THE COURT
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have a Driver's License? Yes ☐ No ☐ Driver's License # _____

Has it been suspended? Yes □ No □ Do you have insurance on every car you drive? Yes ☐ No ☐

Insurance Provider: _____

Please list year and Model of all cars you will drive.

_____

_____

Signature: _____

5th Judicial District Treatment Court Payment Plan

I, _____ agree to the terms and conditions below:

One of the requirements to graduate Treatment Court is that all fines, restitution and Treatment Court fees incurred, must be paid in full prior to graduation from the program. Payment plans will be implemented upon being accepted into the program. Payments are to be made on a monthly basis.

Failure to pay fees couple result in SANCTIONS and/or TERMINATION from Treatment Court.

Any participant receiving Medicaid, Medicare, SSI or Disability should immediately let the Treatment Court Coordinator know in order for other arrangements to be approved.

Funding for substance abuse treatment is determined based on a sliding fee scale. Treatment Court will submit all paperwork to the State for approval. Please do not contact the State directly. Your treatment provider will advise you of the amount you will be responsible to pay. All treatment arrangements and payments are to be made directly with the provider.

Upon entrance to Treatment Court, all clients must meet with the Department of Health & Welfare Mental Health Office. If you receive services, you will be required to pay for the services rendered. Charges are based on the ability to pay.

The base amount for Treatment is assessed monthly. This amount could be increased due to positive samples being sent to the lab for confirmation. Any sample confirmed POSITIVE by the lab will be charged to you for that lab fee. We encourage all Treatment Court participants to be honest and save themselves the added costs in this area. Additional Drug Testing can also increase the base amount.

Treatment Court participants are to pay fees directly to their respective County Courthouse at the fines and fees counter. Be sure to specify that your payment is for Treatment Court fees. Keep all receipts for your records.

I agree to pay the amount of $_____ monthly unless other arrangements have been approved by the Coordinator or Judge.

My Payment Date will be the ____ of each month.

My first payment will be due on or before _To Be Determined__.

Date: _____

_____ _____

Participant Treatment Court Staff

Legal Last Name	First Name	MI	Date of Birth
Other Names Used		IDOC#	

I, the Treatment Court Participant, authorize (**initial** all parties below):

_____ Courts

_____ Prosecuting Attorney or assigned Deputy Prosecuting Attorney

_____ Deputy Public Defender / other Defense Counsel: _____

_____ Local law enforcement agency personnel or jail staff, in their capacity as treatment court team member

_____ Idaho Department of Correction Probation or Pre-sentence staff

_____ Drug Testing Service Provider

_____ Physicians and medical records if necessary

_____ Department of Health and Welfare and its substance abuse management contractor

_____ Idaho Department of Vocational Resources

_____ Housing Services Provider _____

_____ Treatment Provider: River of Hope Behavioral Health / TARC / Preferred Child and Family Services/ Walker Center / ProActive / Alliance Family Services / KH Counseling / Brevity

_____ My diagnosis, urinalysis results, information about my attendance or lack of attendance at treatment sessions, my cooperation with the treatment program, prognosis and any treatment related issues

_____ My photo for Treatment Court and related service projects

The purpose of the disclosure is to inform any person, entity, or agency listed above or participating as part of the Treatment Court Team of my GAIN, attendance at treatment, treatment progress, court appearances, and urinalysis results.

By placing my initials in the spaces below, I specifically understand that the following highly confidential information or records will be released, used, disclosed, received, mutually exchanged or communicated to, by among, or between any person, entity, or agency named in this authorization participating as part of the Treatment court Team:

Mental Health ____ Alcohol/Drug ____

I have read this authorization/had this authorization read/explained to me and I acknowledge an understanding of the purpose of the release of information. I am signing the authorization on my own free will. I understand that this authorization will allow my treatment team to plan and coordinate services I need, to impose appropriate sanctions or rewards based on my behavior and will also allow any person, entity, or agency named in this authorization to be actively involved in my case coordination, evaluation, treatment, planning, or legal proceedings. I further understand that some or all of this information will be discussed in open court, a public forum, where any person in the courtroom may hear the information. I hereby request and give my permission for an open exchange

of information to, by, among, or between, any person, entity or agency named in this authorization or participating as part of the Treatment Court Team.

I understand that this information may include material protected under federal regulations governing confidentiality of alcohol and drug abuse patient records, 42 C.F.R, Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPPA), 45 C.F.R. Parts 160 and 164. Although HIPPA requires that consents be revocable, 42 C.F.R. S 2.35 provides that if I am mandated into treatment through the criminal justice system or I am under legal/court supervision/probation, this authorization will remain in effect and cannot be revoked by me until there has been a formal and effective termination or revocation of my release from confinement, probation, or parole, or other proceeding under which I was mandated into treatment. I also understand that if I do not comply with treatment, my non-compliance will be reported to the judge and the prosecuting attorney/deputy attorney. A photocopy or exact reproduction of this signed authorization shall have the same force and effect as this original.

Compliance and Assurance Questionnaire

*Please read and discuss all items and have client **initial** as they have read and understood each statement*

1. I have a clear understanding of my rights as a client and have been given the opportunity to discuss any of my concerns. _____
2. I understand if I decide not to sign, which is my right, I can be removed from treatment and will be reported to probation/parole, the judge and the prosecuting/deputy attorney. _____
3. I was given this release of information prior to beginning treatment services. _____
4. I have been given the summary of the confidentiality laws. _____
5. I understand that this authorization ends on a formal and effective termination or revocation of my release from confinement, probation, or parole, or other proceeding under which I was mandated to treatment. _____
6. If I am unable to read or comprehend this document, the release of information was read and explained in a manner which I understand. _____
7. I have read this authorization/had this authorization read/explained to me and I acknowledge an understanding of the purpose for the release of information. _____
8. I was provided and have the right to ask for a copy of the signed release of information._____
9. I understand that this authorization will expire one year from the signed date of release or as stated in item 5 above. _____

Full Legal Signature of Client or Authorized Personal Representative	Relationship to Client	Date
Name of Staff Person (print)	Initiating Agency Name/Location	Date

PROHIBITION ON RE-DISCLOSURE AND PROSECUTION: I understand that my alcohol and substance abuse treatment records are protected under federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 C.F.R. Part 2) and that recipients of this information may re-disclose it only in connection with their official duties. Federal rules restrict any use of the information to criminally investigate or prosecute an alcohol or drug abuse patient.