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| RCRC REFERAL application | Rockingham County Recovery Court10 Route 125, Brentwood, NH 03833The Honorable David W. Ruoff presidingChristine McKenna, Recovery Court Coordinator |

**Referral Process Overview:**

Please *fully complete and submit the attached Referral. Applications not fully completed will be sent back to the applicant and may delay entry into the Recovery Court.* The applicant must obtain the position of the line prosecutor assigned to the case as to whether he or she supports the applicant’s admission to Recovery Court. However, the consent of the line prosecutor is not required for the applicant to apply for Recovery Court. Applicants who meet the legal and clinical criteria are eligible to participate in Recovery Court. Eligible applicants may be admitted to Recovery Court in one of three ways:

* By agreement of the parties as part of a fully negotiated plea agreement;
* By order of the Court as part of a capped plea agreement; or
* By order of the Court following a naked plea.

**Legal Screen:**

The Recovery Court Prosecutor will conduct a legal screening to determine if the applicant meets the legal criteria for admission and whether there is any information in the applicant’s history that might merit further assessment and consideration. The Prosecutor shall determine whether, in his or her opinion, the applicant is suitable for Recovery Court based on the applicant’s criminal record and other information available to the State. A finding from the Prosecutor that an applicant is not suitable for Recovery Court does not preclude an applicant from being sentenced into recovery court. However, the Prosecutor’s finding as to suitability will be considered by the Judge in determining whether an applicant should be sentenced to Recovery Court.

**Risk Assessment & Substance Use Disorder Screening:**

The Recovery Court Clinician will contact the applicant to schedule an appointment to conduct a SUD screening and the Ohio Risk Assessment System: Community Supervision Tool (ORAS-CST). To be eligible for Recovery Court, applicant must be found to have a moderate-to-severe substance use disorder AND to be a high-risk to reoffend.

***Note:*** *Applicants may be required to undergo additional screenings or assessments at the discretion of the Recovery Court Team as part of the application process to provide information on whether the Recovery Court program can meet the participant’s clinical and treatment needs. The Recovery Court Coordinator or Clinician will notify the applicant and his/her attorney if any further screenings are assessments are necessary.*

***Failure by the Defendant to return calls or complete screenings in a timely manner may delay resolution of the case.***

**Submit the completed preliminary referral form including attached Releases of Information through email to all parties listed below. Please contact the Recovery Court Coordinator with any questions.**

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| *Christine McKenna, LICSW, MLADC**Recovery Court Coordinator**c*.mckenna@harborcarenh.org*603-658-0188* | *Aaron Dristiliaris**Assistant County Attorney/Recovery Court Prosecutor*a.dristiliaris@rcao.net |

***Date of Referral: \_\_\_\_\_\_\_\_ Person Making Referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

**Name:**  **Phone Number:** ( )

**DOB** *(mm/dd/yy)***:**  **Gender:** 🞏 Male 🞏 Female

***Defense Attorney: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Prosecutor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

**Does the line prosecutor support admission to Recovery Court, if the applicant is eligible? □ yes □ no**

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| ***To be eligible for the RCRC, the applicant must meet the following criteria:*** |
| □ Intends to plead guilty to his/her offense  |
| □ Has a substance use disorder or suspected substance use disorder |
| □ No currently pending charges that preclude acceptance into Recovery Court, as listed in the Referral Instructions. |
| □ No pending DWI-only offense  |
| □ Is a resident of Rockingham County, or intends to move permanently to this jurisdiction, and has a reasonable  means of transportation |
| □ Does not have any of the following charges currently pending:* Capital Murder, RSA 630:1
* First Degree Murder, RSA 630:1-a
* Second Degree Murder, RSA 630:1-b
* Aggravated Felonious Sexual Assault, RSA 632-A:2
* Felonious Sexual Assault, RSA 632-A:3
* Sexual Assault in violation of RSA 632-A:4, I(b) (involving a minor)
* Kidnapping, RSA 633:1
* Trafficking in Persons, RSA 633:7
* Endangering the Welfare of a Child in violation of RSA 639:3, III (involving soliciting a minor for sex)
* Possession of Child Sexual Abuse Images, RSA 649-A:3
* Distribution of Child Sexual Abuse Images, RSA 649-A:3-a
* Manufacture of Child Sexual Abuse Images, RSA 649-A:3-b
* Computer Pornography Prohibited, RSA 649-B:3
* Certain Uses of Computer Services Prohibited, RSA 649-B:4
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| ***To the Applicant: please self-identify Ethnicity, Race, and Sexual Orientation according to the options below. This information is used for reporting purposes only. Information provided is not used in making eligibility or acceptance determinations.*** |
| **Ethnicity:** | **Race:** | **Sexual Orientation:** |
| □ Hispanic or Latino(a) | □ White | □ Heterosexual  |
| □ Non-Hispanic or Latino(a) | □ Black or African-American | □ Homosexual (Gay or Lesbian) |
|  | □ Asian | □ Bisexual |
|  | □ American Indian or Alaska Native |  |
|  | □ Multiracial |  |
|  |  |  |
| □ Participant Refused to answer□ Participant wasn’t asked□ Participant doesn’t know/not sure | □ Participant Refused to answer□ Participant wasn’t asked□ Participant doesn’t know/not sure | □ Participant Refused to answer□ Participant wasn’t asked□ Participant doesn’t know/not sure |

**LEGAL INFORMATION**

|  |  |  |  |
| --- | --- | --- | --- |
| ***Current and/or Pending Charge(s) for referral*** | ***Date of Arrest*** | ***Type*** | ***Docket number for each charge*** |
|  |  | □ *New charge □ VOP*  |  |
|  |  | □ *New charge □ VOP*  |  |
|  |  | □ *New charge**□ VOP*  |  |
|  |  | □ *New charge**□ VOP*  |  |
|  |  |  |  |

Are you currently on Probation and/or Parole? □ No □ Yes (*please indicate below*):

County: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PPO: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Do you have pending charges, suspended sentences, or deferred sentences in other jurisdictions (including out of state)?

□ No □ Yes (*please indicate below*)

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| --- | --- | --- |
| **Name of Court** | **Charge** | **Status of case** |
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**CURRENT LIVING SITUATION**

1. Please describe your current living situation:

□ incarcerated (jail: \_\_\_\_\_\_\_\_)

□ homeless

□ temporary situation (friends, family)

□ stable or permanent situation

1. Current address:

(*Street Address*)

*(City/Town) (State) (Zip)*

1. Is this the address you will be living at if entering Recovery Court? □ No □ Yes
2. If NO, where would you live if entering Recovery Court?

 □ Shelter

 □ Sober Living residence

 □ temporary situation (friends, family)

 □ stable or permanent situation

1. Please provide Address you will be living at if entering Recovery Court:

(*Street Address*)

(*City/Town)*

1. Who will you be living with if entering Recovery Court?

|  |  |
| --- | --- |
| ***Name of household member and/or roommate*** | ***Relationship and phone number to leave a message*** |
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1. Are you the primary caretaker for any minor children? □ No □ Yes (*please indicate below*)

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| --- | --- | --- |
| ***Name of child*** | ***Age*** | ***Relationship*** |
|  |  |  |
|  |  |  |
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**EDUCATION, EMPLOYMENT, INCOME**

1. Are you currently employed? □ No □ Yes (please describe)

 Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Type of Work \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Hours per Week (approximate) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 2. What is your current source of income?

 □ no income

 □ some support from family/friends

 □ employment

 □ SSI or SSDI

 □ other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 3. What is the highest level of education you’ve completed?

 □ 8th grade or lower

 □ 9th grade

 □ 10th grade

 □ 11th grade

 □ HS Diploma

 □ GED/HiSET

 □ some college

 □ College Degree

**HEALTH, MENTAL HEALTH, AND SUBSTANCE USE**

1. Do you have any health, medical, or mental health issues that you think could affect your participation in Recovery Court or that we should be aware of?

□ No □ Yes - *please describe the issues and what accommodations, if any, you think you might need in order to fully participate in Recovery Court:* **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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2. Are you currently being seen by a mental health provider (e.g. therapist, counselor, psychiatrist, etc.)?

**□** No □ Yes – *please indicate provider/clinic*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. What drug(s) have you used in the last 6 months (or prior to prison, if currently incarcerated)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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4. What is your preferred drug(s)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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5. Are you currently or have you been in substance use treatment before? □ No □ Yes (*please describe*)

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5. Are you currently engaged in Medically Assisted Treatment (MAT) (e.g. suboxone, methadone, Vivitrol, naltrexone)?

 □ No/none

 □ Methadone *provider*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 □ Suboxone/buprenorphine *provider*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 □ Sublocade *provider*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 □ Vivitrol/naltrexone provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To the best of my knowledge and belief, I affirm that the information provided herein and through defense counsel is true; that I have not been convicted of a violent offense; that there are no charges pending against me in any court other than those listed above; and that I am otherwise eligible to participate in the Recovery Court Program.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Applicant Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Counsel Signature Date

In addition to this application, please also complete and submit:

□ A Consent to Release Information to communicate with your Attorney regarding your application status

□ A Consent to Release Information to communicate with the Assistant County Attorney regarding your application status

□ Consent to Release Information to the Recovery Court Team regarding your application

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| --- |
| **Upon completion, please email this referral and consents to Release Information to all listed below:** **Assistant County Attorney:** **Aaron Dristriliaris at adristiliaris@rcao.net****Recovery Court Coordinator:****Christine McKenna at c.mckenna@harborcarenh.org****Please contact the Recovery Court Coordinator if you have any questions regarding the referral process or the status of the referral**. |

**AUTHORIZATION AND CONSENT FOR USE AND DISCLOSURE OF PROTECTED**

**HEALTH INFORMATION, MENTAL HEALTH TREATMENT RECORDS &**

**SUBSTANCE USE TREATMENT RECORDS OUTSIDE OF HARBOR HOMES, Inc. d/b/a**

**HARBOR CARE**

I, (Print name of client/patient), date of birth / / authorize Harbor Homes, Inc. d/b/a Harbor Care (inclusive of Keystone Hall and Harbor Care Health and Wellness Center) to disclose, receive, and share my medical, mental health, and/or substance use disorder protected health information (PHI) with those entities and individuals listed below.

I understand my treating providers at Harbor Care will be providing and helping to coordinate aspects of my care and treatment and will therefore need to share certain private health information about my referral, diagnosis and/or treatment for physical health, mental health and/or substance use disorder with my treatment team, with other treating providers, with other individuals or entities involved in my treatment and/or recovery, with entities responsible for payment, and with others listed below as authorized by me or by law.

I authorize Harbor Care to access, use, disclose and communicate both verbally and in writing, private health, substance use disorder and mental health information, including: **[initial all that apply]**

  **Confirmation of Participation in Treatment Only**

 My health care/treatment records

  Test, laboratory and radiology results

  Medications and medication history

 Substance use disorder history and report of current use, treatment history, treatment records,

assessments, diagnoses, treatment plans, attendance, compliance and progress in treatment, progress notes, discharge summaries, and recovery plans/supports.

 I also authorize my treating providers at Harbor Care to release and share information regarding

 my treatment for HIV infection, AIDS and/or STD’s.

 Other:(specify) Communication/collaboration for scheduling and application status/RCRC

I authorize Harbor Care to access, use, disclose and communicate verbally, electronically or in writing as noted above to my past, present, and future treating providers at the following entities for the purpose of my ongoing treatment and recovery and helping me manage my care: **[initial all that apply]**

\_\_\_\_(Name of Agency /Tel #) \_\_Client Defense Attorney\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_(Name of Agency /Tel #) \_\_Rockingham County Attorney\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_(Name of Agency /Tel #) \_\_HOC Rep\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_(Name of Agency /Tel #) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 *\_\_\_\_Other: (specify)*  *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**For the purpose of: [initial all that apply]**

 Monitoring and supporting my ongoing recovery

 Assessing/evaluating my readiness/ability to participate in housing/employment/vocational training

 Confirming compliance with court ordered treatment, probation or parole

 For the purpose of the care and treatment of my children

 Coordination of community-based care

*\_\_\_\_\_\_Other: determining eligibility w/RCRC through scheduling/screening/assessment*

**Acknowledgement of Rights**

I understand that my substance use disorder treatment records are protected under the federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I understand that if my substance use treatment records are disclosed pursuant to this consent, the recipient will be provided a notice of prohibition on re-disclosure. I understand that if my general PHI (i.e. not SUD related) is released pursuant to this consent, the PHI will be subject to re-disclosure by the recipient.

**Revocation**

I understand that I may revoke this consent, orally or in writing by contacting the Privacy Officer at Harbor Care at 603-816-6383 at any time except to the extent that action has been taken in reliance on it. I understand that Harbor Care is unable to take back any disclosures it has already made with my consent. I understand that Harbor Care may not condition treatment on my signing this authorization except if I am receiving substance use treatment services and I refuse to authorize disclosure of my health information for payment purposes.

If not already revoked, this consent will expire on\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. [Example: One year/specified date)/upon my death]

Upon request, I can inspect or obtain a copy of the information I am authorizing to be released. I understand that if I have any questions about disclosure of my substance use treatment records or information, I can contact Harbor Care’s Compliance Officer at 603-816-6383.

**Signature of Patient or Legal Representative**

Signature of patient, legal representative or guardian Date

Authority/Relationship of representative to patient (Attach copy of documentation of authority)

**P: (603) 821-7788**

**F: (603) 821-5620**

**Headquarters:**

**77**

 **Northeastern Blvd**

**Nashua, NH 03062**

**hope@harborcarenh.org**

**www.harborcarenh.org**

**AUTHORIZATION AND CONSENT FOR USE AND DISCLOSURE OF PROTECTED**

**HEALTH INFORMATION, MENTAL HEALTH TREATMENT RECORDS &**

**SUBSTANCE USE TREATMENT RECORDS OUTSIDE OF HARBOR HOMES, Inc. d/b/a**

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 Other:(specify)

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\_\_\_\_(Name of Agency /Tel #) \_\_ Rockingham County Recovery Court (RCRC) team\_\_\_\_\_

\_\_\_\_(Name of Agency /Tel #) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_(Name of Agency /Tel #) \_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_(Name of Agency /Tel #) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 *\_\_\_\_Other: (specify)*  *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**For the purpose of: [initial all that apply]**

 Monitoring and supporting my ongoing recovery

 Assessing/evaluating my readiness/ability to participate in housing/employment/vocational training

 Confirming compliance with court ordered treatment, probation or parole

 For the purpose of the care and treatment of my children

 Coordination of community-based care

  *\_\_\_*  *Other: Screening for eligibility into RCRC\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**Acknowledgement of Rights**

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If not already revoked, this consent will expire on\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. [Example: One year/specified date)/upon my death]

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**Signature of Patient or Legal Representative**

Signature of patient, legal representative or guardian Date

Authority/Relationship of representative to patient (Attach copy of documentation of authority)

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