

# MERRIMACK COUNTY DRUG COURT REFERRAL

Email completed forms to:  
[ang@riverbendcmhc.org](mailto:ang@riverbendcmhc.org)  
[aconnell@nhpd.org](mailto:aconnell@nhpd.org)  
[ccallahan@mcao.net](mailto:ccallahan@mcao.net)

## APPLICANT INFORMATION

Name:		Gender:	
White: <input type="checkbox"/> Black: <input type="checkbox"/> American Indian: <input type="checkbox"/> Asian: <input type="checkbox"/> Native/Hawaiian: <input type="checkbox"/> Hispanic/Latino: <input type="checkbox"/> Other:			
Date of Birth:	Preferred Phone:	Alternative Phone:	
Current Address:	City:	State:	Zip:
Check here if currently homeless: <input type="checkbox"/>	Check here if currently incarcerated: <input type="checkbox"/>	If incarcerated, where?	
Proposed Address(s) if Accepted to Drug Court:			

## LEGAL

PROSECUTER:	EMAIL:
DEFENSE ATTORNEY:	EMAIL:
PROBATION OFFICER:	EMAIL:
CURRENT/PENDING CHARGE:	Docket #:
CURRENT/PENDING CHARGE:	Docket #:
CURRENT/PENDING CHARGE:	Docket #:
CURRENT/PENDING CHARGE:	Docket #:
LIST ARRESTING AGENCY:	DATES OF ARREST:
LIST TOWN/CITY(S) IN WHICH CHARGES ARE FILED:	

### PLEASE CHECK ALL THAT APPLY:

<input type="checkbox"/>	I have signed a release for Merrimack County Drug Court, my attorney and any other party I wish the Drug Court team to communicate with (such as housing options, residential treatment, etc). I understand I can only list one individual or program on a release so I will need to print and sign multiple releases and turn them in with this application. I understand if I initial the box that says "Drug and Alcohol Abuse Information/Treatment" the release is invalid.
<input type="checkbox"/>	This referral is being filed with the <u>assent of both</u> the State and the Defendant
<input type="checkbox"/>	I have <u>never</u> been convicted of negligent manslaughter, murder, felonious sexual assault or rape
<input type="checkbox"/>	I intend to plea & resolve any outstanding charges (in all NH counties) if my application is approved
<input type="checkbox"/>	I am ready to commit to all requirements of Merrimack County Drug Court, and <u>have reviewed the participant handbook</u>
<input type="checkbox"/>	I am interested in being considered for Drug Court as well as the SOAR Program
<input type="checkbox"/>	I understand I am <u>required</u> to live in Merrimack County, even if that means staying in a homeless shelter in county. I understand if I have stable housing in another county, I can explore applying to that Drug Court instead. I understand my PPO will need to approve a residence for me to be able to reside there while in Drug Court/on probation.

Please list below any mental, physical, or developmental challenges that may impact your ability to complete your Drug Court Needs and Risk assessments and what accommodations may be helpful to you:

<b>SIGNATURE OF APPLICANT</b>	<b>DATE</b>
<b>SIGNATURE OF WITNESS</b>	<b>DATE</b>



# Authorization for Access to Health Information

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

This Authorization gives Riverbend Community Mental Health (RCMH) permission to (check all that apply):

<input checked="" type="checkbox"/> Provide written Health Information to the individual or entity named below.	<input checked="" type="checkbox"/> Obtain written Health Information from the individual or entity named below.	<input checked="" type="checkbox"/> Exchange Health Information verbally with the individual or entity named below.
---	--	---

**FEES:** According to policy, there may be a charge for copying records. Please be as specific as possible about the Health Information you are requesting AND include your phone number so that we may contact you if we have questions.

Name (One Name Only): \_\_\_\_\_ Relationship: **ATTORNEY**  
Print NAME of individual or entity with whom you are authorizing RCMH to communicate. Relationship of this individual/entity to the person whose Health Information is involved.

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Please **CLEARLY PRINT** the **COMPLETE** and **VALID** Address and Phone Number of the person or entity named above.

**The Health Information covered by this authorization is to be used for (please check all that apply):**

<input checked="" type="checkbox"/> Treatment Planning	<input checked="" type="checkbox"/> Coordination of Care	<input checked="" type="checkbox"/> Evaluation	<input type="checkbox"/> Emergency Contact	<input type="checkbox"/> Other: _____
<input type="checkbox"/> This request has been initiated by the Client and the Client does not elect to disclose its purpose. <i>If the information to be used or disclosed pertains to alcohol or drug abuse diagnosis, prognosis or treatment, this box may NOT be used.</i>				

**This authorization covers Health Information for ALL dates of Treatment, unless a timeframe is specified in the space below:**  
**FROM** \_\_\_\_\_ **TO** \_\_\_\_\_

**Type of information requested/shared (Please check all requested/shared information below):**

<input checked="" type="checkbox"/> Social History/Intake Summary/Clinical Database	<input checked="" type="checkbox"/> Medical History/ Assessments	<input checked="" type="checkbox"/> Discharge Summaries	<input checked="" type="checkbox"/> Treatment Plans	<input checked="" type="checkbox"/> Clinical/Medical Progress Notes
<input checked="" type="checkbox"/> Medication Lists	<input type="checkbox"/> Information from 3 <sup>rd</sup> Parties	<input checked="" type="checkbox"/> Lab Reports	<input checked="" type="checkbox"/> Psychiatric/ Psychological Evals	<input type="checkbox"/> School Records/Notes
<input type="checkbox"/> Other: _____				

I understand that Riverbend cannot guarantee that the recipient will not re-disclose my protected health information to a third party as the recipient may not be subject to federal laws governing privacy of health information. I am aware that my treatment at Riverbend may not be conditioned on my agreement to authorize disclosure or use of my health information. I understand I may revoke this Authorization at any time, except that the revocation will not have any effect on action taken by the Provider based on this Authorization prior to my revocation. Written revocation is preferred and should be sent to the Privacy Officer, Riverbend CMH, PO Box 2032, Concord NH 03302-2032. **NOTE: Verbal revocation is acceptable and must be recorded by staff on this form. This information must be retained in the record.**

The following types of information **WILL BE INCLUDED UNLESS** you indicate otherwise by initialing below:

Drug and/or Alcohol Abuse Information/Treatment <b>Initial:</b> N/A	Genetic testing <b>Initial:</b>	HIV (AIDS) testing/treatment <b>Initial:</b>
Any Provider that operates a federally assisted alcohol or drug abuse program is prohibited from disclosing information about treatment for alcohol or drug abuse without my specific written authorization unless a disclosure is otherwise authorized by federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR, Part 2).		

This Authorization shall expire ONE YEAR from date of signature (below) unless an earlier date is specified in this space:	_____
--	-------

Signature of Client/Legal Representative \_\_\_\_\_ Date of Signature \_\_\_\_\_

Please PRINT Name of Client/Legal Representative \_\_\_\_\_ Relationship of Legal Representative \_\_\_\_\_

NOTE for RIVERBEND REQUESTS: Please send the requested information to the attention of: _____ _____ at RCMH, PO Box 2032, Concord, NH 03302-2032
--

Original to Chart—Copy to Client/Legal Representative  *Client Declined a Copy.*

# The State of New Hampshire

MERRIMACK COUNTY

SUPERIOR COURT

State of New Hampshire

v.

\_\_\_\_\_

Docket No.: \_\_\_\_\_

The Defendant has filed an application to participate in the Merrimack County Drug Court. The Defendant waives his/her right to a speedy trial for the purpose of completing the Drug Court assessments. A status conference is requested in sixty (60) days.

Date: \_\_\_\_\_

\_\_\_\_\_

Defendant

\_\_\_\_\_

Counsel for Defendant

**\*\*PLEASE RETURN THIS FORM TO MERRIMACK SUPERIOR COURT HOUSE\*\***