Strafford County Mental Health Court
ADMISSION APPLICATION

Docket #: _____ **Referring Agency:** _____ **Date Submitted**:_____

Applicant Name:_____ Age:_____ DOB:_____ Race: _____

Social Security Number: _____/_____/_____Are you a US citizen? _____

Address: _____

Home Phone: _____Work Phone: _____ Cell Phone:_____

Emergency Contact: _____Relation:_____ Phone: _____

Do you have a Guardian? _____ If yes, name of Guardian:_____

Phone # of Guardian: _____

Family and relationships:

Please give information about supportive people in your life:

Name: _____ Relation: _____ Phone Number: _____

Name: _____ Relation: _____ Phone Number: _____

Marital Status: _____

Do you have children: Y or N If yes, how many: _____

Residence:

Name, age and relationship of persons living with you: _____

_____

_____

Criminal Record:

List current charges: _____

_____Court:_____

Arresting Agency: _____ Attorney's name: _____ Prosecutor's name: _____

Currently on Probation: Y or N If so, PPO name: _____

Education:

Do you possess a High School Diploma? Y or N Place and date of GED:_____

Highest level of education: _____ Where? _____

Employment:

Current Employer:_____ Job title: _____

Supervisor's name: _____ Length of time employed there: _____

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Disability:
Do you receive Disability benefits: Y or N If yes, what type: _____

Medical:
Do you have any **medical** problems that restrict your activities: Y or N If yes, please explain:

_____

Insurance
Do you have health insurance? Y or N Name of Insurance: _____

Do you have a primary physician? Y or N Name of Doctor: _____

Mental Health:
Are you currently an active client with a mental health treatment provider? Y or N

If yes, what is the name of the agency and who is your contact person? _____

Current Mental Health Diagnosis:_____

_____

Have you ever been hospitalized for mental health reasons? Y or N

If yes hospitalized, please list dates and places:_____

_____

Are you currently prescribed medication: Y or N

If yes , which medication:_____

_____

Driving
Do you currently possess a driver's license: Y or N

If you do not possess a driver's license, why did you lose it and what will it take for you to get it back:
_____
_____

Military
Have you ever served in the military? Y or N
If yes, what branch? _____ Current status? _____

Substance Use (This will be discussed further in person with MHC Director)

Have you ever participated in a drug treatment program? Y or N
If yes, Where and When:_____

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My first Drug of Choice is: _____ Age of first use: _____

Have you used in the last year?: _____

My second Drug of Choice is: _____ Age of first use:_____

Have you used in the last year?: _____

Mental Health Court Goals:

Mental Health Court is an alternative sentencing program for individuals who possess a desire to make life/behavioral changes. Are there any changes you believe you need to make at this point and time in your life?

_____

_____

Why should I be accepted into Mental Health Court?

_____

_____

I am voluntarily applying to the Mental Health Court. I understand that I must review this application with Blair Rowlett, Mental Health Court Director.

I also understand that as part of my Mental Health Court application and admission process, there will be discussions between Mental Health Court Staffing Team members including; Judge, Prosecutor, Case Manager, Clerk, and Defense Attorney pertaining to my involvement in Mental Health Court. Aside from those parties, this application will be kept confidential. I grant permission for these discussions to take place to assist in determining my eligibility and ongoing progress in Mental Health Court.

I certify that the information that I have provided on this application is correct to the best of my knowledge.

_____ _____
Signature of applicant Date

_____ _____
Witness Date

(For office use only)
Date Closed:_____
Reason: _____

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STRAFFORD COUNTY COMMUNITY CORRECTIONS PROGRAM
Authorization for the Disclosure of Information

I, _____(date of birth_____), hereby authorize and give my consent to:

_____any person or agency providing social, medical, mental health, educational, or correctional services and any employer of mine and its respective agents and employees, to release information limited to following specific types of information: Social, medical, mental health, educational, correctional and employment-related.

Specific medical and psychiatric providers included but not limited to:

__x___ Frisbie Memorial Hospital
__x___ Portsmouth Regional Hospital
__x___ New Hampshire Hospital
__x___ Wentworth Douglas Hospital
__x___ Other _____ANY_____
__x___ Community Partners
__x___ Great Bay Mental Health
__x___ Goodwin Community Health

_____I permit the confidential information to be released only to S.C.C.C.P. and its respective agents and employees.

_____I permit this confidential information to be released only for the following reasons and purposes:

- ✓ Eligibility for SCCCP/MHC
- ✓ Coordination of Pre-Trial Mental Health Services
- ✓ AHC/Step-Down Treatment
- ✓ Discharge Planning
- ✓ Other:___**ANY**_____

Release/Obtain alcohol and drug abuse information that is protected by Federal Confidentiality Rule (42CFR).

__x___ I understand that I am not required to consent to the release of alcohol and/or drug information.
__x___ I give my consent to release/obtain drug and alcohol information
__x__ Defendant/Parent/Guardian initials

_____This authorization to release confidential information may be revoked by me, in writing at any time, except to the extent that action has already been taken.

____This authorization shall expire as follows:

- ✓ Upon Reaching: Program Completion –OR- One year from signing date

_____I understand that I have the right to review any materials provided to Strafford County Community Corrections program to this disclosure.

- ✓ I waive my right to review these materials __x____

_____ _____
Date Signature of Client

_____ _____
Date Witness