IN THE COURT OF COMMON PLEAS
ASHTABULA COUNTY OHIO

THE STATE OF OHIO,	)	CASE NO. ______________________
	)	
Plaintiff	)	JUDGE _________________________
	)	
-vs-	)	
	)	APPLICATION FOR
	)	POST-CONVICTION
_____________________________,	)	MENTAL HEALTH COURT PROGRAM
	)	
Defendant	)	

APPLICATION FOR MENTAL HEALTH COURT ***POST-CONVICTION**** PROGRAM

Originating Court ____________________ **Arresting Agency:** ____________________

List ALL CHARGES 1) In the indictment and 2) Specifically identify all charges in accordance with a Plea Agreement reached with the State of Ohio.

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Application is hereby made on behalf of the above-named defendant for admission to the Ashtabula County Common Pleas Mental Health Court *Post-Conviction* Program. Permission is given for the Adult Probation Department to begin a pre-sentence investigation to help determine the defendant's final eligibility for the Mental Health Court Program. It is understood that no questions will be asked by the Adult Probation Department concerning the charges in this case. I understand that applications must be submitted on all pending cases before any application is considered. I understand that I am ineligible for the Post-Conviction Mental Health Court Program if I have a mandatory prison sentence, unless the sentencing Judge allows my application to Mental Health Court upon completion of any mandatory prison term.

I understand that upon my application to the Mental Health Court Program, I will have appointments and assessments to determine my eligibility for Mental Health Court. I understand that if I fail to comply with any assessment or appointment, or if my behavior is such that I am unable to be assessed for the Mental Health Court Program, I may be found to be ineligible for the Mental Health Court Program. I understand that the recommendation of any counselor, assessor, or other provider is not final and is simply a recommendation. All decisions regarding my treatment plan must be approved by the Mental Health Court Team, and the decision of the Mental Health Court Judge is final. I understand that I am subject to random drug testing any time after this application is submitted and during my time in the Mental Health Court Program.

I further understand that if I am placed into the Mental Health Court Program, an individualized treatment plan will be developed for me. This treatment plan will determine my treatment level and goals, and may include provisions regarding where I live and work. I understand that my failure to comply with my treatment plan will result in treatment adjustments, sanctions, including jail time, and/or termination from the Mental Health Court Program.

I agree to begin attending Mental Health Court in Judge Sezon's courtroom on the Wednesday immediately following my notification of my initial approval of my application by the Prosecuting attorney at 10:00 a.m. If I have questions about this requirement, I will contact the Mental Health Court Coordinator/Probation Officer.

*** The mental health court program is available as an alternative community control sanction which can be imposed at the discretion of the court at time of sentencing upon application of the defendant and after assessment and acceptance by the mental health court treatment team.**

<u>By requesting participation in the Mental Health Court Post-Conviction Program, I hereby knowingly, intelligently and voluntarily waive my rights to a speedy trial whether established by statute, rule of court or under the Constitution Of The United States Of America or the Constitution Of The State Of Ohio.</u>

__________________________________ **Phone : Home:** ___________________
Defendant's Signature **Cell:** ____________________

___________________________________ **Phone:** __________________________
Defendant's Attorney

Attorney's Email Address: ____

File the original of this completed Application with the Ashtabula County Clerk of Courts and submit a time-stamped copy on the same day of filing to:
Ashtabula County Prosecutor's Office, 25 West Jefferson Street, Jefferson, OH 44047

The attached Release of Information for the offenders' most recent/current treatment provider <u>*MUST*</u> be filled out and submitted to the <u>Ashtabula County Prosecutor's Office</u> at the time the application is submitted. <u>DO NOT FILE THE RELEASE OF INFORMATION WITH THE ASHTABULA COUNTY CLERK OF COURTS.</u>

☐ **Please check the box if an application has been filed for ANY other Specialized Docket.**
Date Applied to other Specialized Docket:______________

☐ **Please check the box if the defendant is affiliated with the U.S. Department of Veteran's Affairs.**

PLEASE FILE WITH PROSECUTOR'S OFFICE
DO NOT FILE WITH CLERK OF COURTS

Authorization for Release of Confidential Information

Name: ____________________ Phone: ____________________
DOB: ____________________ SSN (optional): ____________________
Address: ____

Part I: Identification of Entities and Information

I hereby authorize the following entities to exchange [release and/or receive] my health and related information with the other entities indicated below**: (Please check the box AND initial next to all that apply.)**

☐ ___ Catholic Charities of Ashtabula County
4200 Park Avenue
Ashtabula, OH 44004
440-992-2121
CW and/or Supervisor Name:
____

☒ ___ Community Counseling Center
2801 "C" Court
Ashtabula, OH 44004
440-998-4210
Provider name(s) or Program:
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☐ ___ Ashtabula County MHRS Board
4817 State Road, Suite 203
Ashtabula, OH 44004
440-998-3121

☒ ___ Signature Health
4726 Main Avenue
Ashtabula, OH 44004
440-992-8552
Provider name(s) or Program:
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☒ ___ Ashtabula County Adult Probation
87 North Jefferson Street
Jefferson, OH 44047
440-576-9900
Provider name(s) or Program:
____

☒ ___ Lake Area Recovery Center
2801 C Court
Ashtabula, OH 44004
440-998-0722
Provider name(s) or Program:
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☐ ___ Glenbeigh Hospital
2863 State Route 45
P.O. Box 298, Rock Creek, OH 44084
800-234-1001 or 440-563-3400
Provider name(s) or Program:
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☒ ___ Other: Mental Health Court Team
Address: 87 North Chestnut Street
Jefferson, Ohio 44047
Phone: 440-576-9904
Provider name(s) or Program:
____

I authorize the following information to be exchanged [released and/or received] among the entities listed above:

Type of Information to be released OR obtained: (Please initial next to checked items)

☒ ____Diagnostic Assessment	☒ ____Assessment Summaries	☒ ____AOD Diagnosis or Treatment
☒ ____Progress in Treatment	☒ ____Laboratory Results	☒ ____Urine Testing Results
☒ ____Attendance	☒ ____HIV/AIDS Testing or Status	☐ ____Pregnancy Testing Results
☒ ____Progress Notes	☒ ____Discharge Summary	☒ ____Legal Records
☒ ____Psychological Eval.	☒ ____Physiological Testing Results	☒ ____Psychological Testing Results
☒ ____Recommendations	☒ ____Social/Family History	☒ ____Treatment Plans
☒ ____Screening Results	☒ ____Prognosis	

☒ ____School Records/Behavioral Observations ☐ ____Other: ____________________

The following information is excepted/excluded from this release: ____________________

____

Unless otherwise indicated, the information released may include records from other providers that are included in the listed entities records.

Purpose and Intended Use of Disclosure/Exchange of Records: (Check all that apply)

☐ Connection Center planning ☑ Continuity of Care ☑ Evaluation ☑ Treatment
☑ Other: Mental Health Court Assessments and Treatment

Amount of Information to be Released:

☑ Information within date range from Application to MHC to End of Supervision
☑ Information from most recent admission

<u>Part II: Revocation Statements</u>

This Authorization for Release of Confidential Information is effective for one year from the date of signature, or until the following date, event, or condition: ____________________
The effective time frame for this release cannot exceed one year from the date of signature.

I understand that I may revoke this Authorization at any time by delivering written notice to the primary clinical provider indicated in Part I of this document, except to the extent that any of the listed entities acts in reliance on the Authorization prior to my notice of revocation.

I understand that my refusal to sign this Authorization will prevent my participation in some programs, and will prevent potentially vital communication between providers if I am involved in multiple service systems. I understand that my treatment, payment, enrollment, or eligibility for benefits at any listed health care provider will not be conditioned on whether I sign this authorization.

All information disclosed pursuant to this Authorization must include the following statement:

"This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any Patient with a substance use disorder, except as provided at 42 CFR §§2.12(c)(5) AND 2.65."

Client Signature ____________________ Date ____________________
Guardian/Representative Signature ____________________ Date ____________________
If signed by guardian/representative, list the authority to act on behalf of the individual: ____________________

____

Staff Witness Signature ____________________ Date ____________________

PLEASE FILE WITH PROSECUTOR'S OFFICE
DO NOT FILE WITH CLERK OF COURTS