MARION COUNTY MENTAL HEALTH COURT
APPLICATION

PLEASE PRINT

Date:_____ MHC Case #_____

Last Name: _____ First Name:_____ MI: _____

Sex (M/F): _____ Date of Birth: _____ Race: _____

Address: _____City:_____ State: _____ZIP:_____

Mailing Address if different:_____

Telephone: Home: _____ Work: _____ Cell: _____

Driver's license or state ID card: (Circle one) Yes / No DL or ID Card Number: _____

Social Security Number: _____

How long have you lived in Marion County: _____

Emergency Contact**:** Name:_____

Telephone#(s):_____Relationship:_____

Address:_____

Current Charge(s): _____

Case#:_____

Currently in jail (Please Circle one): Yes / No If so, date of incarceration: _____

Previous Convictions:_____

_____

_____

Attorney's Name: _____

Public Defender/Firm Name:_____

Phone Number:_____

The Marion County Mental Health Court does not discriminate against qualified applicants and on the basis of race, color, religion, gender, age, national origin, marital status, handicap (disability) or veteran status or as otherwise prohibited by federal, state or local law.

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The purpose of, and need for, this exchange of information is to provide information about my eligibility for, and participation in, Mental Health Court's application process. The information to be exchanged may include information about my diagnosis which will include, but is not limited to: medical history, including current assessments, diagnosis, treatment and medications, arrest and prior criminal record, risk and alcohol/drug use assessment and diagnosis information.

The Mental Health Court Treatment team members are; the presiding Mental Health Court Judge, Assistant State Attorney, Public Defender, or other Defense Counsel, Mental Health Court Coordinator, Court Alternatives Supervisor/staff, NAMI representative and Law Enforcement in their capacity as a Mental Health Court team member.

I agree that the disclosure of the above information, prior to Mental Health Court termination, sentencing, and / or revocation of this consent shall not be a breach of my right to confidentiality.

I understand that any disclosure made regarding mental health and substance abuse treatment is bound by Part 2 of Title 42 of the Code of Federal Regulations (42CFR, part 2), which governs the confidentiality of mental health and substance abuse patient records and that recipients of this information may re-disclose it only in connection with their official duties, and only with respect to these particular criminal proceedings.

_____ _____

Signature of applicant Date

_____

Name of attorney (Please Print)

_____ _____

Signature of attorney Date

Please return the completed referral along with the Consent for Disclosure to:
The Clerk of the Court, County Criminal, Room 101
or e-mail/scan it to rlewis@circuit5.org
Questions, please call Regina Lewis @ 352-817-6282

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