

SUPERIOR COURT OF CALIFORNIA, COUNTY OF NEVADA

Collaborative Courts- Adult Drug Court Application

Applicant Contact Information
Name: _____ Case Number(s): _____
People vs. _____
Address: _____
Phone: (____) _____ - _____
☐ Applicant is in-custody ☐ Applicant is out of custody
Original filed with court, copy for: ☐ District Attorney ☐ Public Defender ☐ Probation

I, _____ (applicant), hereby apply for admission into the Nevada County Adult Drug Treatment Court program. I make this application voluntarily. I have discussed this application and the express waivers set forth herein with my attorney. My attorney has fully explained to me the terms of this application and all waivers set forth in this application.

1. No Promise of Admission: I understand and agree that by accepting this application, the court is not promising to me that I will be admitted into Adult Drug Treatment Court. The Adult Drug Treatment Court team is only agreeing to accept my application and to consider my potential for admission into Adult Drug Treatment Court.

_____ Initials of Applicant

2. Medical/Psychological Evaluations: I understand and agree that my application may require that I subject myself to testing for and assessment of my medical and/or psychological condition. I agree to submit myself to all such testing. I agree the psychological report will become property of the Adult Drug Treatment Court of which, I will not be permitted a copy. I further agree that the results of all such testing may be distributed to and analyzed by all members of the Adult Drug Treatment Court team, which includes a Superior Court Judge, the District Attorney, the Public Defender, the Probation Officer, a representative from Nevada County Behavioral Health, the Collaborative Courts Program Director, an officer from the Grass Valley Police Department, and representatives of Community Recovery Resources. I expressly waive any claim of confidentiality with respect to the treatment court team and any medical and/or psychological assessments performed on me as a part of the consideration of my application for admission into Adult Drug Treatment Court.

_____ Initials of Applicant

3. Ex Parte Interviews: I further understand and agree that, as part of my consideration for admission, I will meet with, and be interviewed by, members of the Drug Treatment Court team. I understand and agree that there will be no recording of any of these interviews, and that some of these interviews may take place without the presence of my criminal defense attorney. I hereby waive any claim that any such interview by any member of the Drug Treatment Court team violate any of my rights under the Constitutions of the United States and the State of California, including all amendments thereto.

_____ Initials of Applicant

4. No Record of Drug Treatment Court Team Meetings: I understand and agree that meetings of the Drug Treatment Court team to discuss my potential admission into Drug Treatment Court are conducted informally and that no record is kept of the matters discussed in such meetings nor of the persons present during such meetings. I hereby waive any claim that any such meetings of the Drug Treatment Court team, and the absence of any record of the contents of or participants in any such Drug Court team meeting, violate any of my rights under the Constitutions of the United States and the State of California, including all amendments thereto.

_____ Initials of Applicant

5. No Statement or any information procured therefrom, made by the Defendant to any member of the Adult Drug Treatment Court team, or in preparation of a report, that is made during the course of any investigation conducted by the Adult Drug Treatment Court team or treatment providers to determine eligibility, shall be admissible in any action or proceeding brought subsequent to the application process.

_____ Initials of Applicant

6. Public Defender: I understand and agree that if I am admitted into Adult Drug Treatment Court that upon completion of my sentencing, my current counsel will be relieved and the Public Defender, or the Public Defender's designee, will be appointed to represent me.

_____ Initials of Applicant

7. Sentencing Judge: I understand and agree that, in the event that I am denied admission into Adult Drug Treatment Court for any reason, the Superior Court Judge who administers Adult Drug Treatment Court may be the eventual sentencing judge in my case(s). I further understand and agree that such a sentencing judge will have gained information about me as a natural and expected result of the processing of my application for admission by the Drug Treatment Court team. I expressly agree that such a sentencing judge may and can use any such information learned about me during the processing of my application for admission in any eventual sentencing decision by that judge, regardless of whether admitted or denied admission into Adult Drug Treatment Court. Alternatively, I may elect to be sentenced by another judge without the requirement of filing a motion pursuant to Penal Code 170.6 or 170.1.

_____ Initials of Applicant

Applicant Name

Applicant Signature

—

Date

I, _____ am the attorney for the applicant. I have explained the terms and conditions and waivers in this application with my client. I have answered all of my client's questions regarding the terms, and conditions and waivers in this application.

My client has agreed to the following negotiated offer, as discussed with the District Attorney:

List of negotiated terms:

Attorney Signature

Date

This application should have a negotiated offer at the time of submittal by attorney.

NEVADA COUNTY ADULT DRUG COURT
AUTHORIZATION TO DISCLOSE, EXCHANGE AND USE INFORMATION AND RECORDS

Client Name: _____ Date of Birth: _____

Description of the Information to be Released:	
I hereby authorize the agencies <u>checked below</u> as members or participants of a multidisciplinary team to use, disclose and exchange all information related to my substance use disorder diagnosis, information about my attendance at treatment sessions, my cooperation with the treatment program, prognosis, urinalysis and/or breathalyzer results, payment record, treatment plan, and discharge status.	
I specifically authorize the release of the following information and records (minimum necessary):	
☐ Mental Health Treatment	☐ HIV/AIDS Test Results
☐ Alcohol & Drug Abuse Treatment (per description above)	☐ Educational information and records (specify): _____

Client: Please check all applicable agencies:

To Treatment Providers:	
☐ Nevada County Behavioral Health Department	☐ Granite Wellness Centers (GWC)
☐ Wellpath	☐ Aegis Medical Services
☐ Sierra Nevada Memorial Hospital	☐ Common Goals
☐ Western Sierra Medical Clinic	☐ Chapa-De Indian Health
☐ Residential Treatment Facilities (facility name):	
☐ Other Treatment Provider (provider name):	
To Non-Treatment Organizations: must include one or more individual's names	
☐ Nevada County Probation Department (Provide name of your Probation Officer if not listed below):	
Jeff Goldman, Steve Sinclair, Angelina Coffey, Jeremy Vance, Joshua Browning, Amy Moon, Clinton Shifflett, Kristina Guevel	
☐ Nevada County Superior Court	
Alissa L. Bjerkhoel, Courtney C. Abril, Robert S. Tice-Raskin, B. Scott Thomsen, Kelly Babineau, Tonya Clark	
☐ Nevada County Public Defender	
Jennifer Mouzis, Thomas Angell, Bruce Kapsack, Carmen Pacheco, Whitney Youngman, Kenly Flanigan, Joseph O'Hair, Katie Finch	
☐ Your Attorney (provide name below if not Public Defender listed above):	
☐ Nevada County District Attorney	
Jesse Wilson, David Reynolds, Casey Ayer, Lydia Stuart, Shelly Talbot, Alicia Nottingham	
☐ Grass Valley Police Department	
Alex Gammelgard, Ernesto Alvarado	
Description of the Purpose for the Use or Release of the Information	

NEVADA COUNTY ADULT DRUG COURT
AUTHORIZATION TO DISCLOSE, EXCHANGE AND USE INFORMATION AND RECORDS

I understand that the purpose of and need for the disclosure is to provide the above selected agency(ies) with the necessary information about my involvement and participation in Nevada County Adult Drug Court.

- I authorize the use and/or disclosure of my individually identifiable health information as described for the purpose listed above.
- I understand that this authorization is voluntary and will not affect my treatment, payment, enrollment or eligibility for benefits, but I may not be able to receive the benefits of participation in this Multidisciplinary Team.
- I understand that this consent is effective immediately and will remain in effect and cannot be revoked by me until there has been a formal and effective termination or revocation of my release from confinement, probation or parole, or other proceeding under which I was mandated into treatment.
- I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing confidentiality of alcohol and drug abuse patient records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act (HIPAA), 45 CFR Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise allowed in these regulations. I also understand that recipients of this information may re-disclose it only in connection with their official duties.
- I understand that I have the right to receive a copy of this authorization.³

Signature of Client

Date

Translator Signature (if applicable)

Language

Clinician approval (if applicable⁴)

For Agency Use Only

1. If this form is being used to authorize the release of psychotherapy notes, as that term is defined by HIPAA, a separate authorization form must be used to authorize release of any other health information. (see 45 CFR § 164.508(b)(3)(ii))
2. Verification of identity and legal authority to act as personal representative is required.
3. Under HIPAA, the individual must be provided with a copy of the authorization when it has been requested by a covered entity for its own uses and disclosures (see 45 CFR §164.508(d)(1),(e)(2)). It is recommended the client be offered a copy in all instances.
4. If authorization is for the disclosure of mental health information for purposes other than treatment and is signed by the individual who is the subject of the information, a clinician (physician, licensed psychologist, social worker with a master's degree in social work, or licensed marriage and family therapist) who is in charge of the patient must approve the disclosure and sign where indicated. (Cal. W&I Code §5328(b))