14th Judicial Circuit Veterans Treatment Court

VTC Referral Form

TO: VTC COORNIDATOR: Shonta N. Covington **DATE:** _____

FROM: _____

Please review this referral for possible participation in VTC:

Defendant's Name: _____

Date of Birth: _____ Social Security Number: _____

Aliases: _____

Date of Arrest: _____ Bay County Jail? Yes _____ No _____

Is the Defendant a Veteran or Service Member? Yes _____ No _____ If Yes, please include:

Military Branch Served: _____

Time of Service (MM/YYYY): From: _____ To: _____

Charge(s) and Case Number(s): _____

Attorney of Record: _____ Phone Number: _____

Attorney of Record Email Address: _____

Please complete the questionnaire on the following pages before sending in referral.

TO: State Attorney, Larry Basford **DATE:**

FROM: VTC Coordinator, Shonta N. Covington

I have reviewed the referral contained herein and have determined:

Defendant is NOT eligible for participation: Reason(s) being_____ _____

_____

The State recommends this defendant for participation in TJC.

Staffing Committee Determination: **DATE:** _____

The Staffing Committee does/does not recommend this defendant for participation in VTC.

_____

_____

ABILITY TO PARTICIPATE IN TREATMENT

The Veterans Treatment Court clinical program consists mostly of traditional and evidence-based psychotherapy, counseling and teaching treatment approaches. They are provided in both individual and group formats. Readings, homework assignments and learning exercises are common. It is therefore very important that each participant demonstrate the ability and willingness to self-identify relevant problems and participate in developing appropriate treatment goals to focus on while they are involved in the program. It is important that participants demonstrate intact memory, reasonable judgment, ability to communicate, and basic behavior control so that the treatment sessions can be of some help. A positive past treatment history is usually a good indicator of future success. Participants who have never had treatment experience can also demonstrate ability and willingness to participate in the program during their initial evaluations by the VTCC, VJO and clinical members of the Veterans Treatment Court Team. Reasonable accommodations can be made for participants with minor impairments, and the clinical team will continue to assess and assist participants throughout their time in the program. Participants' case plans and participation agreements will outline each individual's goals and objectives. These can be changed and updated as participants progress through the five program phases. The clinical team will consider and review each individual's abilities on a case by case basis. Alternate programs may be more appropriate for Veterans with substantial impairments in these areas. It is also important for participants to understand that, for the ENTIRE TIME they are in the Veterans Treatment Court, they agree to NOT CONSUME ALCOHOLIC BEVERAGES OR USE ILLICIT DRUGS. This applies to all participants regardless of whether they have drug/ alcohol charges or whether or not they are considered to have a drug or alcohol problem.

REFERRAL PROCESS

Defendants/Veterans with open cases can be referred by any Assistant Public Defender, any Assistant State Attorney or private attorney as well as other agencies and/or professionals in the community. If the defendant/Veteran is referred by an agency or professional outside of the court system, the defendant's attorney of record will be notified. Once notified, the defendant's attorney has to agree on the referral before the defendant will be evaluated for Veterans Treatment Court (VTC).

The VTC referral packet must be completely filled out and submitted along with the release of information (ROI). On the top of the ROI where it says, "TO", please leave it blank. This allows VTC to request records from any agency, treatment center, hospital, ect. that has provided treatment to the veteran/defendant. As well as speak with the defendant's family, friends and other individuals as needed.

Once the referral is completed with the ROI, it should be sent to the VTC Coordinator for review. The Coordinator will then research the defendant's current charge/s, legal history, mental health treatment, substance usage and military status to determine if the defendant is appropriate for VTC. If the defendant is appropriate, the Coordinator will complete an assessment and send the referral to the state attorney assigned to VTC for approval. The defendant/veteran will also be staffed with the VTC Committee members and Judge Smiley before final approval.

If approved for VTC, the defendant's attorney will be notified and be responsible for pleading the defendant/veteran in the defendant's original court with orders to complete VTC as part of the plea. The defendant/veteran will then be placed on the docket for the next available VTC court date and the case will be transferred to Judge Smiley's court.

EXCLUSIONS

Veterans Court will not accept any defendant who has been incarcerated more than once within the Department of Corrections.

Veterans Court will not accept any defendant if the defendant is currently charged with or who has previously been convicted, regardless of adjudication of any offenses listed below:

Murder

Manslaughter

Attempted Murder

Aggravated Assault

Aggravated Battery/Attempted Aggravated Battery

Aggravated Stalking

Kidnapping/Attempted Kidnapping

False imprisonment of Child under 13

Luring or Enticing a Child

Unlawful Throwing/placing/Discharging Device/Bomb

Sexual Battery/Attempted Sexual Battery

Lewd or Lascivious Battery/Attempted Lewd or Lascivious Battery

Lewd or Lascivious Molestation

Lewd or Lascivious Conduct

Lewd or Lascivious Exhibition

Arson or Attempted Arson

Burglary or Attempted Burglary and is 1st or 2nd Degree Felony

Robbery or Attempted Robbery

Car Jacking or Attempted Carjacking

Home invasion Robbery/Attempted Home Invasion

Attempted or Lewd or Lascivious of Elderly/Disabled

Attempted or Sexual performance by a Child

Computer Pornography

Lewd or Lascivious Exhibition on a Computer

Transmission of Child pornography

Selling or Buying of Minors

Poisoning Food of Water

Aircraft piracy

Abuse of a Dead Human Body

Treason

Carried/Possessed/or used a firearm or dangerous weapon

**Some exclusions are subject to F.S. 948.08 (7)(a) relating to veterans and service members. These exclusions may be modified at the request of the ASA and approval by the court.

VETERANS INFORMATION

CLIENT NAME: _____
Date of Admission_____

Branch of Service

___ Air Force ___ Army ___ Coast Guard ___ Marines
___ National Guard ___ Navy ___ Reserves

Enlistment Date: __ **Discharge Date:** _____ **Years of Service:** _____

Military Occupational Specialty: _____

Military Discharge Reason *(Check One)*:

___ Still serving, not yet discharged	Military Rank:	
___ Honorable	Military Rank:	
___ Entry-level separation	Military Rank:	Details:
___ General (including medical)	Military Rank:	Details:
___ Other than honorable	Military Rank:	Details:
___ Clemency	Military Rank:	Details:
___ Bad conduct dishonorable	Military Rank:	Details:

Additional Relevant Information from DD Form 214 or Other Source:

___ Yes ___ No

Details:

_____

_____

Any criminal convictions prior to military service:

___ Yes ___ No

If yes, highest offense grading of conviction prior to military service

___ Felony ___ Misdemeanor ___ Summary

Awards and Decorations:

___ Yes ___ No

Details:

_____

_____

Rank Reduction:

___ Yes ___ No

If yes, Disciplinary Action / Rank Reduction: _____

_____

Military Incarceration:

___ Yes ___ No

Details:

_____

_____

Deployed Abroad:

___ Yes ___ No

If yes, Total Months: _____

Location(s): _____

Have you ever been exposed to military combat?

___ Yes ___ No

If yes, Number of deployments to a combat zone:

___ 1 ___ 2 ___ 3 ___ 4 ___ 5 ___ 6 or more

Conflict Eras of Service:

___ WW II (1941 – 1946) ___ Korea (1950 – 1955) ___ Vietnam (1961 – 1975)

___ Persian Gulf – Iraq/Kuwait ODS (1990 – 2003)

___ Persian Gulf – Afghanistan OEF (2001 – present)

___ Persian Gulf – Iraq OIF (2003 – 2010)

___ Persian Gulf – Iraq OND (2010 – present)

Military Service Comments:

_____

_____

Witness or Involvement:

___ Yes - Number of times:

_____

___ No

Military-Related Mental Illness / Behavioral Health Issues:

__ Depression ___ Bipolar ___ Schizophrenia ___ Psychosis

PTSD: ___ Yes ___ No

Details: _____

TBI ___ Yes ___ No

Details: _____

IED, or HME ___ Yes ___ No

Details: _____

MST ___ Yes ___ No

Times and Locations: _____

Date Referral Sent to VA / VJO: _____

Veteran eligible for Benefits:

___ Yes Date Assessment Received from VA/VJO:

_____

___ No Date of receipt of ineligibility notice:

_____

Benefits Utilized Previously:

___ Compensation and Pension

Details:

_____

___ Education

Details:

_____

___ Housing Services

Details:

_____

___ VA Health Insurance

Details:

_____

___ Other Insurance

Details:

_____

___ Vocational Services

Details:

_____

Appendix B

AUTHORIZATION FOR THE RELEASE AND EXCHANGE OF HEALTH INFORMATION

CLIENT NAME:	DATE OF BIRTH:	SOCIAL SECURITY NUMBER:
CLIENT ADDRESS:		

I request that health information regarding my care and treatment be released as set forth on this form:
In accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPPAA), I understand that

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, AND CONFIDENTIAL *HIV RELATED INFORMATION only if I place my initial on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of *HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my *HIV-related information without authorization. If I experience discrimination because of the release or disclosure of *HIV-related information, I may contact the Florida State Commission of Human Rights at (850) 488-7082 or Toll Free at 1-800-342-8170. This agency is responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be re-disclosed by the recipient (except as noted above in Item 2), and this re-disclosure may no longer be protected by federal or state law.
6. This authorization does not authorize you to discuss my health information or medical care with anyone other than the attorney or governmental agency specified in item 9(b).
7. Name and address of health provider or entity to release this information:

☐ ☐ ☐ Other: _____

8. Name and address of person(s) or category of person to whom this information will be sent:
Veteran's Court of the Fourteenth Judicial Circuit
C/O Shonta Covington, Veterans Court Coordinator
300 E. 4th Street, Panama City, FL
Phone: 850.767.3567 Email: covingtons@jud14.flcourts.org

9. (a). Specific information to be released:
☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent by other health care providers.
☐ Medical Record from: (date) _____ to (date) _____ ☐ Other: _____

Include: *(Indicate by Initialing)*: _____ **Alcohol/Drug Treatment** _____ **Mental Health Information** _____ ***HIV-Related Information**

(b). By initialing here ____ I authorize _____ to discuss my health information with my attorney, or a
(Name of individual health care provider)

governmental agency, listed here: **Veteran's Court of the Fourteenth Judicial Circuit**
Shonta Covington, Veterans Court Coordinator

10. Reason for the release of information:
☒ Continuation/Coordination of Care
☐ At the request of the individual
☐ Other: _____

11. Date or event on which this authorization will expire:
☒ Termination of Probation: _____
☐ One Year from Signature
☐ Other: _____

12. If not the patient, name of person signing form:

_____

13. Authority to sign on behalf of patient.

_____

All items on this form have been completed and my questions about this form have been answered and I have been provided a copy.

X _____ _____
Signature of patient or representative authorized by law Date

***Human Immunodeficiency Virus that causes AIDS.**
The Florida State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

PRIVACY ACT AND PAPER WORK REDUCTION ACT INFORMATION: The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Act. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless is displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 2 minutes. This includes the time it will take to read the instructions, gather the necessary facts and fill out this form. The execution of this form does not authorize the release of information other than that specifically described below.

The information requested on this form is solicited under Title 38 U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164; 5 U.S.C. 552a; and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if the information including the last four of your Social Security Number (SSN) and Date of Birth (used to locate records for release) is not furnished completely and accurately, VA will be unable to comply with the request. The Veterans Health Administration may not condition treatment, payment, enrollment or eligibility on signing the authorization. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act system of records notices identified as 24VA10P2 "Patient Medical Record – VA", 08VA05 "Employee Medical File System Records (Title 38)-VA" and in accordance with the Notice of Privacy Practices. VA may also use this information to identify veterans and person claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

TO: DEPARTMENT OF VETERANS AFFAIRS *(Name and Address of VA Health Care Facility)*

VA Gulf Coast
400 Veterans Avenue
Biloxi, MS 39531

LAST NAME- FIRST NAME- MIDDLE INITIAL	LAST 4 SSN	DATE OF BIRTH

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL, OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

BCVTC Team - 14th Judicial Circuit Court; Offices of Public Defender and State Attorney; Offices of State and County Probation (JCS); Vet Center; Court Coordinator

PURPOSE(S) OR NEED: Information is to be used by the individual for:

☐ TREATMENT ☐ BENEFITS ☐ LEGAL ☐ EMPLOYMENT ☒ OTHER *(Please specify)* Veterans Tx Court

INFORMATION REQUESTED: Check applicable box(es) and state the extent or nature of information to be provided:

☐ HEALTH SUMMARY *(Prior 2 Years)*

☐ INPATIENT DISCHARGE SUMMARY *(Dates)*: _____

☒ PROGRESS NOTES:

- ☐ SPECIFIC CLINICS *(Name & Date Range)*: _____
- ☐ SPECIFIC PROVIDERS *(Name & Date Range)*: _____
- ☒ DATE RANGE: Throughout Veterans involvement in Bay County Veterans Court

☐ OPERATIVE/CLINICAL PROCEDURES *(Name & Date)*: _____

☒ LAB RESULTS:

- ☐ SPECIFIC TESTS *(Name & Date)*: _____
- ☐ DATE RANGE: Throughout Veterans involvement in Bay County Veterans Court

☐ RADIOLOGY REPORTS *(Name & Date)*: _____

☒ LIST OF ACTIVE MEDICATIONS: _____

☐ FLU VACCINATION *(Dose, Lot Number, Date & Location)*: _____

☒ OTHER *(Describe)*: Contact information; VJO and AT involvement; progress in Tx

LAST NAME- FIRST NAME- MIDDLE INITIAL	LAST 4 SSN	DATE OF BIRTH

SENSITIVE DIAGNOSES: REVIEW AND, IF APPROPRIATE, COMPLETE WHEN RELEASE IS FOR ANY PURPOSE OTHER THAN TREATMENT.

I request and authorize Department of Veterans Affairs to release the information pertaining to the condition(s) below for the non-treatment purpose(s) listed in this authorization.

☒ DRUG ABUSE ☒ ALCOHOLISM OR ALCOHOL ABUSE ☐ SICKLE CELL ANEMIA

☐ HUMAN IMMUNODEFICIENCY VIRUS *(HIV)*

I understand that information on these sensitive diagnoses may be released for treatment purposes without me checking the above boxes, and will be released even if the boxes are unchecked unless I indicate by checking the box below that I do not want this information released for this specific disclosure.

☐ **I do not want sensitive diagnoses released for treatment purposes under this specific authorization. I realize this does not impact other future requests unrelated to this authorization.**

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing records. Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

I understand that the VA health care provider's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions.

EXPIRATION: Without my express revocation, the authorization will automatically expire.

☐ AFTER ONE-TIME DISCLOSURE, IF ALL NEEDS ARE SATISFIED

☐ ON _____ *(enter a future date other than date signed by patient)*

☒ UNDER THE FOLLOWING CONDITION(S): _____

PATIENT SIGNATURE *(Sign in ink)*	DATE *(mm/dd/yyyy)*
LEGAL REPRESENTATIVE SIGNATURE *(if applicable) (Sign in ink)*	DATE *(mm/dd/yyyy)*
PRINT NAME OF LEGAL REPRESENTATIVE	RELATIONSHIP TO PATIENT

FOR VA USE ONLY

TYPE AND EXTENT OF MATERIAL RELEASED

DATE RELEASED	RELEASED BY: