

Marion County Veterans Treatment Court (MCVTC) Application Packet

MCVTC offers eligible veterans with criminal charges the chance to enter an alternative treatment and sentencing program to address underlying substance use and/or mental health concerns. MCVTC utilizes a collaborative team approach and evidenced-based practices to assist veterans who are ready and willing to make changes in their lives.

Eligibility Requirements

To be eligible for MCVTC, a potential participant must:

1. For purposes of the MCVTC, the term 'Veteran' means a person who meets one or more of the following requirements:
 - i. A person who served in the active military, naval, or air services, and who was discharged under honorable conditions;
 - ii. A person who has received a service-connected disability rating from the US Department of Veterans' Affairs.
 - iii. A person who currently serves or formerly served in the Reserves or National Guard and accomplished the following:
 - a. Completed basic military training under honorable conditions;
 - b. Met basic technical training requirements for awarding their AFSC, MOS or Rate;
 - c. Completed at least 12 months of their obligated military service in either the Reserves or National Guard;
2. Be an adult with qualifying charges filed in Marion County Circuit Court;
3. Reside in Marion County or in a residence approved by the Marion County Parole and Probation Department;
4. Have a substance use and/or mental health diagnosis that can be addressed through the court;
5. Have the mental capacity and ability to appreciate the consequences of the legal proceedings and fully understand the expectations and conditions of the court contract;
6. Clear any outstanding warrants; and
7. Have a willingness to participate.

Admission Requirements

Potential participants that meet the above eligibility requirements must complete the following steps before being considered for admission into MCVTC:

1. Complete the MCVTC **Application Packet**, including a copy of DD214 and/or NGB Form 22, DD Form 256 or DD Form 257 and turn it into the MCVTC Coordinator;
2. Attend a **MCVTC Hearing**, followed by an **Orientation** verified by the MCVTC Coordinator, held on Thursdays from 10:00 - noon in Courtroom 4A.
3. Complete a Substance Use and/or Mental Health **Assessment** (conducted by the VA or other approved treatment provider) and provide results to the MCVTC Coordinator.

If you have any questions about this application or MCVTC in general, please contact:

Rita Rehome-Myers, MCVTC Coordinator
PO Box 12869
Salem, OR 97309
(503) 589-3230 or (971) 718-2313
Fax: (503) 588-5109
rita.rehome-myers@ojd.state.or.us

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Marion County Veterans Treatment Court (MCVTC) Application

Today's Date (mm/dd/yyyy): _____ Referred by: _____

Legal Last _____ First _____ MI ____ Preferred Name _____

Mailing Address _____ City _____ State _____ Zip _____

Physical Address if different from Mailing:
Address _____ City _____ State _____ Zip _____

Email _____

Primary Phone _____ Secondary Phone _____

Message Phone _____ Belongs to: Family Partner Friend Work Other

Case Number(s) _____

Charge(s) _____

SID# _____ Current Attorney _____

Signature (**Required**) _____

1. Have you ever served in the U.S. Military? Yes No
If Yes, which branch? (check all that apply)
 Air Force Marines Coast Guard Merchant Marines
 Army Navy National Guard
Dates of Service (mm/yyyy)? _____ to _____ (if unsure, approximate)

2. What status have you served? (check all that apply)
 Active Inactive Retired Reserve

3. Have you served in a foreign war or conflict? Yes No
If Yes, name of conflict(s) _____
Date in conflict? (List all dates if more than one) _____

4. What type of discharge do you have?
 Honorable General Bad Conduct Other Than Honorable Dishonorable

5. Are you receiving Veterans benefits? Yes No Disability Rating _____ %
Do you have a VA caseworker? Yes No Caseworker Name _____
Caseworker phone _____ Caseworker Email _____

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Marion County Veterans Treatment Court (MCVTC) Application

Personal Information:

Age _____ Date of Birth (mm/dd/yyyy) _____ Sex _____ Marital Status _____

High School Graduate: Yes No **or** GED: Yes No **If No**, highest grade completed _____

College Graduate: Yes No

If Yes (check all that apply): Vocational Associate's Bachelor's Graduate

Current or Last School Attended _____

Are you currently on probation: Yes No Probation Officer _____ Phone _____

Ethnicity (check all that apply): African American Alaskan Native Asian/Pacific Islander
 Caucasian Native American Hispanic Other

Primary Language (check one): English Spanish Russian Other _____
 Japanese Mandarin Cantonese Laotian Cambodian Vietnamese Korean

Residence:

Time at current residence _____ yrs _____ months Date moved in (mm/yyyy) _____

Please name the people you live with:

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Is your current residence a safe, drug/alcohol free environment: Yes No

Employment:

Are you employed: Yes No Employer _____ Start Date (mm/yyyy) _____

Supervisor/Contact _____ Phone Number _____

Employer Address _____

Wage \$ _____ per Hour or Month Average Number of Hours per Week _____

If not employed, what is your primary source of income and amount? _____

Transportation:

Driver's License: Yes No **If Yes**, ODL# _____ **or** State _____ DL# _____

License Status: Current Expired Suspended for _____ Suspended for life

If you do not drive, how do you get around (check all that apply):

Bicycle Family/Friends Walk Public Transportation Taxi Other

Marion County Veterans Treatment Court (MCVTC) Authorization for Use and Disclosure of Information

By signing this form I, _____, authorize all record holders to disclose, and use, the following specific confidential information as needed to coordinate and effectively administer my treatment plan, while I am a participant in the Marion County Veterans Treatment Court.

This release applies, but is not limited to the following agencies, organizations, and individuals: Marion County Veterans Treatment Court, Marion County Health Department, Marion County Jail Medical Staff and contract employees, Department of Human Services, mental health providers and physicians, other benefit providers and care givers, and other entities as needed.

The specific information to be released and disclosed includes, but is not limited to: dates of involvement, evaluation and diagnostic impressions, treatment recommendations, treatment plans, progress in treatment, results of abstinence testing, aftercare recommendations, prognosis, reasons for termination of services, incident reports, and criminal records.

Marking "YES" below, will allow for MUTUAL EXCHANGE of information, back and forth, among the record holders and the people or programs described in this authorization.

MUTUAL EXCHANGE: Yes No

The information will be released to the Marion County Veterans Treatment Court, its partners and staff. The purpose is to evaluate eligibility, and/or acceptability for mental health, and/or substance abuse treatment services and my treatment attendance, prognosis, compliance, and progress in accordance with the VTC monitoring criteria.

This release will expire upon the completion, termination, or withdrawal from the VTC.

Identifying information that may include treatment status, where necessary, will be disclosed in the normal course of VTC proceedings open to the public, and I hereby authorize such disclosure.

I also understand that as a result of my involvement in the VTC identifying information may be entered into computer information systems such as Odyssey, and Oregon Treatment Court Management System (OTCMS).

I can revoke this authorization at any time. Any revocation will not affect any information previously disclosed. I understand that state and federal law protects information about my case. I understand what this agreement means and I approve of the disclosures listed. I am signing this authorization of my own free will. I understand cancellation or revocation of this agreement will result in termination from the VTC program.

I understand that the information used and disclosed as stated in this authorization may be subject to re-disclosure and no longer protected under federal or state law. However, I also understand that federal or state law may restrict re-disclose of HIV/AIDS, mental health, and drug/alcohol diagnosis, treatment, or referral information.

Signature _____ Date (mm/dd/yyyy) _____

Print Last Name _____ First Name _____ MI _____

SID# _____ DOB (mm/dd/yyyy) _____

Case# _____

Name of VTC Staff (print) _____ Date (mm/dd/yyyy) _____

THIS IS A TRUE COPY OF THE ORIGINAL AUTHORIZATION DOCUMENT

Signature of person making copies _____ Printed Name _____

Marion County Veterans Treatment Court (MCVTC) Authorization for Use and Disclosure of Information

This is a Voluntary Form. I understand the covered entity (alcohol or other drug abuse treatment or mental health provider) is not conditioning treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization.

This authorization for use and disclosure of information is necessary to participate in the VTC program.

Identifying information, where necessary, will be disclosed in the normal course of court proceedings open to the public, and I hereby authorize the same.

Redisclosure: Federal regulations (43 CFR Part 2) prohibit making any further disclosure of Alcohol and Drug information; state law prohibits further disclosure of HIV/AIDS information (ORS 433.045, OAR 333-12-0270); and state law prohibits further disclosure of mental health, substance abuse treatment, vocational rehabilitation and developmental disability treatment information from publicly-funded programs (ORS 179.505, ORS 344.600) without specific written or oral authorization. *Medical/mental health/drug treatment records submitted to the Court will be filed separately from the official Court file. However, these medical/mental health/drug treatment records are subject to subpoena and are as a result subject to potential public disclosure.*

Cancellation/revocation of this authorization will result in termination from the VTC program.

Using This Form

1. Terms Used:

- **Mutual exchange.** A “yes” allows information to go back and forth between the record holder and the people or programs listed on the authorization.
 - **Team.** A number of individuals or agencies working together regularly. The agencies of which the team is composed must be identified on this form.
2. **Assistance:** When possible, your attorney should complete this form with you. **Be sure you understand the form before signing.** Feel free to ask questions about the form and what it allows. You may substitute a signature with making a mark or by asking an **authorized** person to sign on your behalf.
 3. **Guardianship/Custody:** If the person signing this form is a personal representative, such as a guardian, a copy of the legal documents that verify the representative’s authority to sign the authorization must be attached to this form. Similarly, if an agency has custody, and their representative signs, their custody authority must be attached to this form.
 4. **Cancel/Revoke:** If you later want to cancel this authorization, contact the treatment court program coordinator. Cancellations can be oral or in writing. Federal regulations do not require that the cancellation be in writing for Drug and Alcohol Programs. No more information will be disclosed or requested after the authorization is cancelled, except to the extent that action has been taken in reliance on it. Cancellation/revocation will result in termination from the program.
 5. **Minors:** If you are a minor, you may authorize the disclosure of mental health or substance abuse information if you are age 14 or older; for the disclosure of any information about sexually transmitted diseases or birth control regardless of your age; for the disclosure of general medication information if you are age 15 or older.
 6. **Special Attention.** For information about HIV/AIDS, mental health, genetic testing, or alcohol/drug abuse treatment, the authorization must clearly identify the specific information that may be disclosed.
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Marion County Veterans Treatment Court Team consists of the following:

Marion County Circuit Court Judge	Marion County – Office of the District Attorney
Defense Attorney(s)	Treatment Providers and Counselors
Court Coordinator	Court Evaluator
Court Assessor	U.S. Department of Veterans Affairs
Oregon Department of Veterans Affairs	Community Partner
Marion County Sheriff – Court Services, Parole & Probation, Enforcement, Institution	

Marion County Veterans Treatment Court (MCVTC) Application Essay

Please provide response to the following prompts (in your own words):

Can you describe any current or past incidents where alcohol or drugs have had negative consequences on your life?

Have you ever been diagnosed with a mental health condition? If so, are you currently seeing a provider or taking medications?

Please tell us how the Veterans Treatment Court may be able to help support you:

**Marion County Veterans Treatment Court (MCVTC)
Application Essay**

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Please tell us what you understand about the Veterans Treatment Court:

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PORLAND VA Substance Abuse Treatment Intake Information

The SATP (Substance Abuse Treatment Program) is housed at the VA Medical Center's Vancouver Campus

The Address is:

**1601 East 4th Plain Blvd., Building 11
Vancouver, WA 98661
(on the first floor)**

**To schedule an intake appointment, please call:
503-220-8262 ext. 31841**

Intakes occur on **Wednesday mornings at 8 a.m.** Once your appointment is scheduled you will show up in the morning and complete some paperwork and sit through a brief orientation. You will then sit down with a case manager and discuss your interest in the program. Your case manager will discuss what treatment options are most appropriate for your individual situation, goals, and court mandates. Please allow **3 hours for this entire process.**



AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

VETERAN'S INFORMATION			
Name ,		Date of Birth	VA File/Claim Number
Social Security Number	Military Service Number	Branch of Service	Conservatorship Number
CLAIMANT'S INFORMATION			
Name (If other than Veteran)			Date of Birth
Social Security Number		Relationship to Veteran	
DISCLOSURE INFORMATION			
I authorize the Oregon Department of Veterans Affairs (ODVA) to use and disclose a copy of any/all protected health information concerning the above-referenced veteran.			
<p>The information is to be released to:</p> <ul style="list-style-type: none"> ◆ U.S. Department of Veterans Affairs, including, but not limited to Veterans Benefits Administration, Veterans Health Administration, VA Vet Centers, VA Vocational Rehabilitation, VA Cemetery Systems, VA Appointed Fiduciary. ◆ Board of Veterans' Appeals ◆ Salem Veteran Service Office Staff and ODVA Staff. ◆ Various benefit providers and other entities as needed (including Offices of Members of Congress) ◆ Any/All health care providers ◆ Insurance providers ◆ Other (list name and relationship of others who may speak on behalf of veteran): Marion County Veterans Treatment Court - All team members 			
The information is to be used for the purpose of preparation, presentation, and prosecution of my claim.			
Limitation of Consent – I authorize disclosure of records related to treatment for all conditions except:			
<input type="checkbox"/> HIV/AIDS information	<input type="checkbox"/> Mental Health information	<input type="checkbox"/> Drug/Alcohol diagnosis, treatment, or referral information	
<input type="checkbox"/> Genetic testing information			
SIGNATURE AND AUTHORIZATION			
<p>I may revoke this authorization in writing at any time. If I revoke my authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any use or disclosure already made with my permission cannot be undone.</p> <p>To revoke this authorization, please send a written statement to the attention of: ODVA Privacy Officer, 700 Summer Street NE, Salem OR 97301-1285, and state that you are revoking this authorization.</p>			
Unless revoked, this authorization remains in effect until termination of ODVA's POA or upon the following date:			
I have received a copy of ODVA's Notice of Privacy Practices. I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment, or referral information. I have read this authorization and I understand it.			
Signature		Date	
Description of personal representative's authority: (if applicable)			
<input type="checkbox"/> Spouse	<input type="checkbox"/> Power of Attorney	<input type="checkbox"/> Court-appointed Guardian	
<input type="checkbox"/> Signature of Witness:	<input type="checkbox"/> Signature of Witness:		



REQUEST FOR AND AUTHORIZATION TO RELEASE MEDICAL RECORDS OR HEALTH INFORMATION

Privacy Act and Paperwork Reduction Act Information: 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 Social Security Number (SSN) (the SSN will be used to locate records for release) is not furnished completely and accurately, Department of Veterans Affairs 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 systems of records notices identified as 24VA10P2 "Patient Medical Record - VA" and in accordance with the Notice of Privacy Practices. You do not have to provide the information to VA, but if you don't, VA will be unable to process your request and serve your medical needs. Failure to furnish the information will not have any affect on any other benefits to which you may be entitled. If you provide VA your Social Security Number, VA will use it to administer your VA benefits. VA may also use this information to identify veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law. 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 Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it 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 instructions, gather the necessary facts and fill out the form.

ENTER BELOW THE PATIENT'S NAME AND SOCIAL SECURITY NUMBER IF THE PATIENT DATA CARD IMPRINT IS NOT USED.

TO: DEPARTMENT OF VETERANS AFFAIRS (Print or type name and address of health care facility)	PATIENT NAME (Last, First, Middle Initial)
VA Portland Health Care System 3710 SW US Veterans Hospital Rd, Portland OR 97209	
	SOCIAL SECURITY NUMBER

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

Marion County Veterans Treatment Court under Marion County Circuit 100 High St. NE PO BOX 13069, Salem OR 97309

VETERAN'S REQUEST: I request and authorize Department of Veterans Affairs to release the information specified below to the organization, or individual named on this request. I understand that the information to be released includes information regarding the following condition(s):

DRUG ABUSE ALCOHOLISM OR ALCOHOL ABUSE TESTING FOR OR INFECTION WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV) SICKLE CELL ANEMIA

INFORMATION REQUESTED (Check applicable box(es) and state the extent or nature of the information to be disclosed, giving the dates or approximate dates covered by each)

COPY OF HOSPITAL SUMMARY COPY OF OUTPATIENT TREATMENT NOTE(S) OTHER (Specify)

Assessments, treatment plan and progress updates, UA results, attendance at appointments.

PURPOSE(S) OR NEED FOR WHICH THE INFORMATION IS TO BE USED BY INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

Two way verbal communication and written communication to coordinate with legal requirements.

NOTE: ADDITIONAL ITEMS OF INFORMATION DESIRED MAY BE LISTED ON THE BACK OF THIS FORM

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 the records. Redisclosure of my medical records by those receiving the above authorized information may be accomplished without my further written authorization and may no longer be protected. Without my express revocation, the authorization will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on (date supplied by patient); (3) under the following condition(s):

Veteran officially graduates or terminates from the treatment court

I understand that the VA health care practitioner'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.

DATE (mm/dd/yyyy)	SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO SIGN FOR PATIENT (Attach authority to sign, e.g., POA)

FOR VA USE ONLY

IMPRINT PATIENT DATA CARD (or enter Name, Address, Social Security Number)	TYPE AND EXTENT OF MATERIAL RELEASED	
	DATE RELEASED	RELEASED BY



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TO: DEPARTMENT OF VETERANS AFFAIRS (Print or type name and address of health care facility)	PATIENT NAME (Last, First, Middle Initial)
Salem Vet Center Suite 250 2645 Portland Road SE Salem, OR 97301	
	SOCIAL SECURITY NUMBER

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

Marion County Veterans Treatment Court under Marion County Circuit 100 High St. NE PO BOX 13069, Salem OR 97309

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