Fostering Attachment Treatment Court (FATC)

Referral Info & Checklist

Need help or have questions?

Mike Blakely
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Jennifer Laib
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Instructions:

- Staff potential referral with Jennifer Laib, and/or Mike Blakely for assistance with discussing FATC program with parent. Provide parent with the FATC pamphlet and handbook.
- Invite parent to observe FATC and provide them with the date, time and location of the next court session. Send email to Jennifer, **and** Mike with the parent's name and the date they will be observing.

TO START REFERRAL PROCESS

- **Step 1.)** Complete the initial documents list with parent and email completed documents to Mike Blakely and/or Jennifer Laib. Please connect with Mike Blakely and/or Jennifer Laib to get copies of these documents e-mailed to you. If parent is accepted into the program, please continue to Step 2.
- **Step 2.)** Gather the documents from the supplemental documents list and email to Mike Blakely and/or Jennifer Laib. The documents will then be sent to CCBC Records for redaction and the caseworker will be copied.
- Once the referral has been redacted by the discovery team, Jennifer, and/or Mike will forward the completed referral to the FATC Coordinator

FATC referrals must include the following:

STEP 1.

INITIAL DOCUMENTS

- ODHS - FATC ROI
- OJD - FATC ROI
- ODHS Referral sheet
- SCMS Face sheet

FATC will ask for the following if participant is accepted into program:

STEP 2.

SUPPLEMENTAL DOCUMENTS

- CPS Assessment (if completed)
- Shelter Report
- Jurisdictional Judgement
- Drug and Alcohol Assessment
- Mental Health Assessment/Eval
- Recent Court report (if completed)

Helpful Hints:

- Reach out to Mike, and/or Jennifer if you'd like help discussing FATC with your parent
- A calendar with dates to observe FATC are located outside Mikes cube (546)
- FATC court sessions are held on the 1st, 2nd, 4th Wednesday at 10:30am in Juv 1

ODHS Referral for Fostering Attachment Treatment Court (FATC)

Date of Referral:
Caseworker:
Supervisor:

A referral to FATC is not appropriate if:

- Parent is a violent offender and/or sex offender
  - 34 US Code 10613
- Parent is a medical marijuana card holder
- Parent has significant mental health and/or developmental delays

Case name:	Case #:
Parent Name:	Address:
Phone Number:	Email:

Date of Jurisdiction: Parent's Attorney:	Court Hearings: ▪ Review: ▪ CRB: ▪ Perm:

Pending Warrant: Pending Criminal Charges:	Probation/Parole Officer: County:

Mental Health Provider: Agency:	Drug and Alcohol Provider: Agency:

Child Name:	Child DOB:	Placement:
Child Name:	Child DOB:	Placement:
Child Name:	Child DOB:	Placement:

PLEASE FILL OUT COMPLETELY AND SUBMIT WITH FATC REFERRAL PACKET- Grant reporting requirement

LEGAL NAME: _____

GENDER: ☐ Female ☐ Male

RACE: ☐ Asian ☐ Black ☐ Indian ☐ Native American ☐ Other ☐ White

ETHNICITY: ☐ Hispanic ☐ Non-Hispanic ☐ Refused

Employment: ☐ Unemployed ☐ Student ☐ Vocational Training

☐ Part-time ☐ Full-time Employer: _____

Start date: _____

☐ Disabled Collecting SSI ☐ Yes ☐ No If Yes, Start date: _____

Drug of Choice: (List top drugs used)

1. _____ 2. _____ 3. _____

Medical Assisted Treatment: ☐ Yes ☐ No If Yes, ☐ Suboxone ☐ Methadone

Appointment date**:** _____

Diagnosed Conditions: Diagnosis date: _____

Diagnosis type: ☐ Primary ☐ Non-MH Medical Cond. ☐ Diagnosis in progress ☐Other

Guideline: ☐ DSM-V ☐ Other

Drug relation: ☐ Substance Induced Disorder ☐ General medical condition

☐ neither ☐ other

Category: ☐ Psychotic Disorder ☐ Major Depressive Disorder ☐ Bipolar Disorder

☐ PTSD ☐ Obsessive compulsive disorder ☐ Borderline Personality Disorder

Prescriptions: 1. _____ 2. _____ 3. _____ 4. _____

Assessment date: _____

Assessment tool: ☐ WRNA ☐ LS/CMI ☐ PSC

Assessment Risk: ☐ Very High ☐ High ☐ Moderate ☐ Low ☐ Very Low

Authorization for Disclosure, Sharing and Use of Individual Information

This form allows the referral, coordination and oversight of provider services.

Legal last name:	**First name:**	MI:	Date of birth:
Other names:			
Address:	City:	State:	ZIP:
Phone:	Email address:		
Identification type: Case number:			
Legal last name of representative (*if any*):	**First name:**		MI:
Relationship to the person listed above:			
Address:	City:	State:	ZIP:
Phone:	Email address:		

When I sign this form, I authorize those I name to give specific personal information about me. If I answer "yes" to "mutual exchange," I allow agencies I name to share information back and forth. This is so they can provide better services to me.

Release FROM:

Purpose of the disclosure, sharing and use:
To facilitate the evaluation, participation, case management, coordination of services and shared understanding of behavioral changes of the above named individual in the Fostering Attachment Treatment Court (FATC) program.

Entity name: DHS — Child Welfare (CW)

Specific information to be disclosed: Other (please list specific information below)

Attendance, participation, assessments, evaluations, progress notes, treatment plans, laboratory records, medical records, and case planning information.

Date of records: Other (please type in here):	All
Contact person: ODHS caseworker	Address: 4600 25th Ave NE
City, state and ZIP: Salem, OR 97301	
Phone number: 503-378-6800	Email address:
Fax number:	Mutual exchange: ◉ Yes ○ No

Expiration date or event*: ODHS Case Closure

Do you request special health information to be released? ◉ Yes ○ No

Specially protected information: (*There may be additional laws for use and disclosure if there is the type of record or information listed in this box. I understand that **no information** will be disclosed **unless** I or my representative **initial next to the information types below.***)

HIV or AIDS: _____ **Mental health:** _____ **Genetic testing:** _____

Alcohol or drug diagnoses, treatment, referral: _____

Is there any specific information **not** to release? ○ Yes ◉ No

Release TO:

Purpose of the disclosure, sharing and use:
To facilitate the evaluation, participation, case management, coordination of services and shared understanding of behavioral changes of the above named individual in the Fostering Attachment Treatment Court (FATC) program.

Entity name: Other (type name here): Fostering Attachment Treatment Court (FATC)

Specific information to be disclosed: Other (please list specific information below)

Attendance, participation, assessments, evaluations, progress notes, treatment plans, laboratory records, medical records, and case planning information.

Date of records: Other (please type in here):	All
Contact person: Janalee Weitman	Address: 2970 Center St. NE
City, state and ZIP: Salem, OR 97301	
Phone number:	Email address:
Fax number:	Mutual exchange: ◉ Yes ○ No
Expiration date or event*: ODHS Case Closure	
Is there any specific information **not** to release? ○ Yes ◉ No	

Purpose of the disclosure, sharing and use:
To facilitate the evaluation, participation, case management, coordination of services and shared understanding of behavioral changes of the above named individual in the Fostering Attachment Treatment Court (FATC) program.

Entity name: Other (type name here): Options Counseling & Family Services

Specific information to be disclosed: Other (please list specific information below)

Attendance, participation, assessments, evaluations, progress notes, treatment plans, laboratory records, medical records, and case planning information.

Date of records: Other (please type in here):	All
Contact person: Any and all Options Counseling and Family Services employees	Address: 2645 Portland Rd NE Suite 120 1515 Liberty St SE
City, state and ZIP: Salem, OR 97301 Salem, OR 97302	
Phone number: 503-390-5637 503-951-6280	Email address:
Fax number: 503-393-3135/ 503-468-3130	Mutual exchange: ◉ Yes ○ No
Expiration date or event*: ODHS Case Closure	
Is there any specific information **not** to release? ○ Yes ◉ No	

Purpose of the disclosure, sharing and use:
To facilitate the evaluation, participation, case management, coordination of services and shared understanding of behavioral changes of the above named individual in the Fostering Attachment Treatment Court (FATC) program.

Entity name: Other (type name here): Bridgeway Community Health

Specific information to be disclosed: Other (please list specific information below)

Attendance, participation, assessments, evaluations, progress notes, treatment plans, laboratory records, medical records, and case planning information.

Date of records: Other (please type in here):	All
Contact person: Any and all Bridgeway Community Health employees	Address: 750 Front St. NE
City, state and ZIP: Salem, OR 97301	

Phone number: 503-363-2021	Email address:
Fax number:	Mutual exchange: ◉ Yes ○ No
Expiration date or event*: ODHS Case Closure	
Is there any specific information **not** to release? ○ Yes ◉ No	

Purpose of the disclosure, sharing and use:
To facilitate the evaluation, participation, case management, coordination of services and shared understanding of behavioral changes of the above named individual in the Fostering Attachment Treatment Court (FATC) program.

Entity name: Other (type name here): Soaring Heights Recovery Homes	
Specific information to be disclosed: Other (please list specific information below) Attendance, participation, assessments, evaluations, progress notes, treatment plans, laboratory records, medical records, and case planning information.	
Date of records: Other (please type in here):	All
Contact person: Any and all Soaring Heights Recovery Homes employees	Address: P.O. Box 20614
City, state and ZIP: Keizer, OR 97307	
Phone number: 971-719-4963	Email address:
Fax number:	Mutual exchange: ◉ Yes ○ No
Expiration date or event*: ODHS Case Closure	
Is there any specific information **not** to release? ○ Yes ◉ No	

Purpose of the disclosure, sharing and use:
To facilitate the evaluation, participation, case management, coordination of services and shared understanding of behavioral changes of the above named individual in the Fostering Attachment Treatment Court (FATC) program.

Entity name: Other (type name here): Iron Tribe Network	
Specific information to be disclosed: Other (please list specific information below) Attendance, participation, assessments, evaluations, progress notes, treatment plans, laboratory records, medical records, and case planning information.	
Date of records: Other (please type in here):	All
Contact person: Any and all Iron Tribe Network employees	Address: 17763 SE 82nd Dr. Suite A
City, state and ZIP: Gladstone, OR 97027	
Phone number: 503-344-6710	Email address:
Fax number: 503-344-6832	Mutual exchange: ◉ Yes ○ No
Expiration date or event*: ODHS Case Closure	
Is there any specific information **not** to release? ○ Yes ◉ No	

Purpose of the disclosure, sharing and use:
To facilitate the evaluation, participation, case management, coordination of services and shared understanding of behavioral changes of the above named individual in the Fostering Attachment Treatment Court (FATC) program.

Entity name: Other (type name here): Marion County Parole & Probation/ Community Corrections	
Specific information to be disclosed: Other (please list specific information below) Attendance, participation, assessments, evaluations, progress notes, treatment plans, laboratory records, medical records, and case planning information.	
Date of records: Other (please type in here):	All

Contact person: Any and all Community Corrections employee	Address: 3610 Aumsville Hwy. SE
City, state and ZIP: Salem, OR 97317	
Phone number: 503-588-8492	Email address:
Fax number:	Mutual exchange: ◉ Yes ○ No
Expiration date or event*: ODHS Case Closure	
Is there any specific information **not** to release? ○ Yes ◉ No	

Purpose of the disclosure, sharing and use:
To facilitate the evaluation, participation, case management, coordination of services and shared understanding of behavioral changes of the above named individual in the Fostering Attachment Treatment Court (FATC) program.

Entity name: Other (type name here): ODHS Self Sufficiency Program	
Specific information to be disclosed: Other (please list specific information below) Attendance, participation, assessments, evaluations, progress notes, treatment plans, laboratory records, medical records, and case planning information.	
Date of records: Other (please type in here):	All
Contact person: Any and all ODHS Self Sufficiency Program employee	Address: 1660 Oak St. SE
City, state and ZIP: Salem, OR 97301	
Phone number: 503-378-6327	Email address:
Fax number:	Mutual exchange: ◉ Yes ○ No
Expiration date or event*: ODHS Case Closure	
Is there any specific information **not** to release? ○ Yes ◉ No	

Purpose of the disclosure, sharing and use:
To facilitate the evaluation, participation, case management, coordination of services and shared understanding of behavioral changes of the above named individual in the Fostering Attachment Treatment Court (FATC) program.

Entity name: Other (type name here): Salem Housing Authority	
Specific information to be disclosed: Other (please list specific information below) Attendance, participation, assessments, evaluations, progress notes, treatment plans, laboratory records, medical records, and case planning information.	
Date of records: Other (please type in here):	All
Contact person: Any and all Salem Housing Authority employees	Address: 360 Church St. SE
City, state and ZIP: Salem, OR 97301	
Phone number: 503-588-6368	Email address:
Fax number: 503-588-6465	Mutual exchange: ◉ Yes ○ No
Expiration date or event*: ODHS Case Closure	
Is there any specific information **not** to release? ○ Yes ◉ No	

Purpose of the disclosure, sharing and use:
To facilitate the evaluation, participation, case management, coordination of services and shared understanding of behavioral changes of the above named individual in the Fostering Attachment Treatment Court (FATC) program.

Entity name: Other (type name here): St. Francis Family Housing	
Specific information to be disclosed: Other (please list specific information below) Attendance, participation, assessments, evaluations, progress notes, treatment plans, laboratory records,	

medical records, and case planning information.	
Date of records: Other (please type in here):	All
Contact person: Any and all St. Francis Family Housing employee	Address: 1820 Berry St. SE
City, state and ZIP: Salem, OR 97302	
Phone number: 503-588-0428	Email address:
Fax number:	Mutual exchange: ◉ Yes ○ No
Expiration date or event*: ODHS Case Closure	
Is there any specific information **not** to release? ○ Yes ◉ No	

Purpose of the disclosure, sharing and use:
To facilitate the evaluation, participation, case management, coordination of services and shared understanding of behavioral changes of the above named individual in the Fostering Attachment Treatment Court (FATC) program.

Entity name: Other (type name here): Morrison Child & Family Services	
Specific information to be disclosed: Other (please list specific information below) Attendance, participation, assessments, evaluations, progress notes, treatment plans, laboratory records, medical records, and case planning information.	
Date of records: Other (please type in here):	All
Contact person: Any and all Morrison Child & Family Services employees	Address: 3857 Wolverine St. NE Bldg C Suite 22
City, state and ZIP: Salem, OR 97305	
Phone number: 503-258-4568	Email address:
Fax number:	Mutual exchange: ◉ Yes ○ No
Expiration date or event*: ODHS Case Closure	
Is there any specific information **not** to release? ○ Yes ◉ No	

Your acknowledgment

- I was given the chance to ask questions about this form and what it does.
- I understand what this form means and I approve of the disclosures or releases listed.
- I understand that state and federal law protect information about services I receive from any listed:
  » Agency » Business » Organization » Person
- This authorization is valid for one year from the date I sign it unless otherwise noted.*
- I understand my representative or I can cancel this authorization. However, information shared before I cancel cannot be undone. I can orally cancel an authorization for drug and alcohol information. All other cancellation requests must be written. I must provide any request to cancel to the agency, business, organization or person that is providing the information.
- I understand that federal or state law prohibits re-disclosure of the following, without authorization by me or my representative:
  » Drug and alcohol diagnosis » HIV and AIDS information » Mental health
  » Referral information » Treatment records » Vocational rehabilitation records
- I understand that information that does not have re-disclosure restrictions may be re-disclosed. Re-disclosed information may no longer be protected under federal or state law.
- I understand someone may need to contact me about this form to confirm my identity. They may also need to get more information.
- I understand that deciding not to sign this form may:
  » Prevent agencies from deciding if I am eligible for certain programs.
  » Prevent me from getting referrals. It may also make coordination of provider services more difficult.

» Affect my ability to get health services if it is necessary to share information.
» Keep the Oregon Health Plan (OHP) or Medicaid from paying for a service because they do not have authorization.

• **I am signing this authorization of my own free will.**

Signature:	
Printed name:	Date:
Signature of legal representative (*if any*):	
Printed name:	Date:

If the person legally authorized to act for the person on this form signs, they must give evidence of their authority to do so.

Security statement

This form may contain your personal information. If you return the form by email there is some risk it could go to someone you don't want to have the information. If you are not sure how to send a secure email, consider using regular mail or fax.

For questions or help to complete this form, please contact the agency you work with.

- *Oregon Health Authority: 503-947-2340*
- *Oregon Department of Human Services: 503-945-5600*
- *Oregon Commission for the Blind: 971-673-1588*
- *Oregon Department of Employment: 800-237-3710*
- *Oregon Department of Education: 503-947-5600*
- *Oregon Housing and Community Services: 503-986-2000*
- *Oregon Department of Justice: 503-378-4400*
- *Oregon Department of Corrections: 503-945-9090*
- *Oregon Youth Authority: 503-373-7205*
- *Oregon State Police: 503-378-3720*

* *This authorization is valid for one year from the date I sign it, unless otherwise noted.*

OREGON SPECIALTY COURT
CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

By signing this form, I, _____or my authorized representative, consent to and authorize the Fostering Attachment Treatment Court (FATC) and the following individuals and entities:

□ JUDGE MANUEL PEREZ, the judge who presides over this Program.

□ JANALEE WEITMAN, the coordinator for this Program.

□ BRIDGEWAY RECOVERY SERVICES, including all employees of the treatment provider that are assigned to the specialty court team in connection with my participation in this Program.

□ OPTIONS COUNSELING AND FAMILY SERVICES, including all employees of the treatment provider that are assigned to the specialty court team in connection with my participation in this Program.

□ MARION COUNTY JUVENILE CONSORTIUM, the attorney that is assigned to the specialty court team in connection with my participation in this Program.

□ DEPARTMENT OF JUSTICE assigned to the specialty court team in connection with my participation in this Program.

□ MARION COUNTY PAROLE AND PROBATION, the probation officers assigned to the specialty court team in connection with my participation in this Program.

□ DEPARTMENT OF HUMAN SERVICES CHILD WELFARE AND SELF-SUFFICIENCY, the caseworkers who are assigned to the specialty court team in connection with my participation in this Program.

□ SALEM HOUSING AUTHORITY, who is assigned to the specialty court team in connection with my participation in this Program.

□ ST FRANCIS SHELTER, who is assigned to the specialty court team in connection with my participation in this Program.

□ IRON TRIBE, who is assigned to the specialty court team in connection with my participation in this Program.

□ ST. JOSEPH'S, who is assigned to the specialty court team in connection with my participation in this Program.

□ SOARING HEIGHTS, who is assigned to the specialty court team in connection with my participation in this Program.

to disclose my information and communicate with one another regarding my eligibility and/or acceptability for the Program, to monitor my progress in and compliance with substance abuse and/or mental health treatment services, and to monitor my compliance with Program requirements and directives. This includes sharing with each other my assessment results, diagnostic conclusions, prescribed medications, unprescribed substance use, screening results, referrals to treatment and other services, treatment attendance records, progress in treatment, compliance with treatment, and compliance with Program requirements and directives. My information may also be disclosed in connection with an audit or evaluation of the performance of the Program and to determine whether the Program is following best practices such as the Oregon Specialty Court Standards.

I understand that my alcohol, drug, and/or mental health treatment records are protected under applicable state and federal law and regulations including, without limitation, ORS 3.450, the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and 45 C.F.R. Parts. 160 & 164.

I understand that I have no legal right to participate in the Program and that this consent is required in order to participate in this Program. This consent form is used to obtain information to assess my compliance and progress toward achieving the Program's objectives. The Program is separate from treatment programs and other services I may receive while in the Program.

I understand that my treatment provider may not condition treatment, payment, enrollment, or eligibility for the treatment provider's benefits on the provision of this consent.

If I sign this consent my information will be disclosed to the people or programs listed on this form. The information disclosed to an entity covered under the HIPAA Privacy Rules may only be redisclosed with my written authorization or under other provisions of the HIPAA Privacy Rules. Information disclosed pursuant to this authorization may no longer be protected by the HIPAA Privacy Rules if it is disclosed to people or programs that are not subject to the HIPAA Privacy Rules. For example, the judge and attorneys who receive the information are not subject to the HIPAA Privacy Rules. However, the other federal regulations that protect my information will continue to apply. Information disclosed to a person or entity not covered by the HIPPA Privacy Rules may only redisclose my records with my written authorization or under other provisions of the federal regulations.

Identifying information including treatment status and compliance with Program requirements may be disclosed in the normal course of court proceedings open to the public and recorded in court data information systems available to the public, and I hereby authorize such disclosure. I understand that it is possible that an observer could make the connection between specialty court participation and substance abuse and/or mental health treatment. I understand that information disclosed during court proceedings will no longer be protected by the HIPAA Privacy Rules.

I understand that my treatment records and other treatment related information cannot be used to investigate, initiate, or substantiate criminal charges against me. However, federal laws and regulations do not protect information related to the commission of a crime, or any threat to commit a crime, while on

Program premises or against Program personnel. Additionally, federal laws and regulations do not protect information related to suspected child abuse or neglect from being reported under state law to appropriate state or local authorities.

I understand that I may revoke this consent at any time. I understand that this consent agreement is a condition of the Program and if I revoke my consent I will be terminated from the Program. Revoking my consent will not affect any information that was previously disclosed.

This consent will expire upon my completion of, or separation from, the Program.

Any violation of federal law and regulations is a crime and suspected violations may be reported to the U.S. Attorney for Oregon (see https://www.justice.gov/usao-or/our-locations) or the Substance Abuse and Mental Health Services Administration (SAMHSA)(see https://www.samhsa.gov/about-us/contact-us).

I have read and understand the contents of this consent. I fully understand my rights and I am signing this consent voluntarily. I understand that, by signing this consent form, I am authorizing disclosure of my protected health information, as outlined above, to the persons and/or entities listed on this form. I further understand that this consent will be in effect for the duration of time I am in the Program. I am not under the influence of drugs or alcohol.

Printed Name: _____

Signature: _____ Date: _____

Witness Name: _____ Position: _____

Witness Signature: _____ Date: _____