50th JUDICIAL DISTRICT – COURT OF COMMON PLEAS
VETERANS TREATMENT COURT

Butler County

124 W. Diamond Street -:- PO Box 1208 -:- Butler, PA 16003-1208
724-431-2156 TDD Users 724-284-5473

The Honorable Timothy F. McCune, Judge

VETERANS TREATMENT COURT REFERRAL INFORMATION

Referral Source/Attorney:	**Phone number:**	**Date of Referral:**
E-Mail:		

CLIENT & COURT INVOLVEMENT INFORMATION

Client's name:		Date of Birth:	Gender:	Race:
Home Address:		Social Security #:		
DL#:	Possess a driver's license: ☐ Yes ☐ No	Status: ☐Valid ☐Suspended ☐Expired		
Home Phone #: Cell Phone #:		Email:		
Currently incarcerated in Butler County Prison: ☐ Yes ☐ No		If yes, admittance date:		
Has client ever served in the U.S. Military/Armed Forces? ☐ Yes ☐ No Branch of Military:_____ Dates of Service: _____to _____ Discharge Status (Honorable, General, etc.):_____ List Service in a Combat Theater & Location, If known: _____				
Is the client currently on probation/parole? ☐ Yes ☐ No If yes, who is the probation/parole officer : _____				

MENTAL HEALTH/ DRUG & ALCOHOL INFORMATION

Attach recent Mental Health/Psychological Evaluation if applicable*	Treatment Provider(s):
Mental Health Diagnosis:	If none, when last in service(s):
Drug & Alcohol Use: ☐ Yes ☐ No Drug(s) of Choice: _____	If yes, current treatment provider(s):

SOME INDICTATORS OF SEVERE MENTAL ILLNESS (check those observed or reported):

☐ Auditory/Visual Hallucinations	☐ Irrational/Bizarre Behavioral	☐ Delusional Thoughts
☐ Hx of psychiatric hospitalization	☐ Suicidal Behavior	☐ Severe Depression
☐ Manic Behavior/speech, racing thoughts	☐ Self-injurious Behavior	

***In order to fully process this referral, please attach a psychiatric or psychological evaluation that has been completed within the last two years. If one has not been completed, please have one completed prior to submitting the Veterans Treatment Court Referral.**

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BUTLER COUNTY SPECIALTY COURTS REFERRAL

I am filing this Referral to be considered for a Specialty Court Program.

This Referral is being made with regard to the following case(s):

Case Number(s)	OTN(s)	Offense(s)	Crimes Code(s)	Grade(s)	Count(s)

Signify your acknowledgement and acceptance to the following statements by initialing in the spaces provided.

_____ 1. I understand and acknowledge that if my Referral is accepted, I will be required to enter a plea of guilty in the above matter(s) or stipulate to the parole/probation violation before a Specialty Court Judge.

_____ 2. I understand and accept that by applying to a Specialty Court, I am waiving all of my speedy trial rights pursuant to Rule 600 of the Pennsylvania Rules of Criminal Procedure, as well as my right to be sentenced subsequent to my plea of guilty, within ninety (90) days pursuant to Rule 704 of the Pennsylvania Rules of Criminal Procedure.

_____ 3. I understand and agree to execute all Consents to Release Confidential Information to a Specialty Court Team regarding any present or past Substance Abuse Treatment Programs, Medical Treatment, Prescribed Medication, and/or any other information a Specialty Court Team may require to design a proper treatment program for me and to monitor the same.

_____ 4. I understand and acknowledge that upon submitting this Referral, I will not need to attend any further hearings on the cases involved with this Referral pending a notification of acceptance or rejection into a Specialty Court Program.

_____ 5. However, I also understand and acknowledge if this Referral is for Reconsideration for admission into a Specialty Court, until I receive notice of acceptance or rejection into a Specialty Court, I will continue to appear at all proceedings in my case(s).

_____ 6. I understand and acknowledge that upon acceptance into a Specialty Court, this case will be continued generally pending the successful completion or termination of my Specialty Court Program.

_____ 7. I understand and acknowledge should my Referral be rejected, my case(s) shall continue through the normal criminal procedure process.

_____ 8. I understand that upon Acceptance I will comply with all the requirements of the Butler County Court of Common Pleas Specialty Court Program I am accepted into.

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The facts set forth in the Referral are true and correct to the best of my knowledge, information, and belief. Iunderstand that false statements made herein are subject to the penalties of 18 Pa.C.S.A. § 4904 relating to Unsworn Falsification to Authorities.

Signature of Referral	**Date**
Signature of Defense Attorney	**Date**

FILING INSTRUCTIONS

REFERRAL FORMS SHOULD BE FORWARDED TO THE SPECIALTY COURTS COORDINATOR
Amy Petricca: PHONE: 724-431-2156, FAX: 724-285-8762, 124 West Diamond Street, P.O. Box 1208, Butler, PA 16003
The original Referral must be filed with the Specialty Court Coordinator within 72 hours (3 business days) upon signing.

DO NOT COMPLETE THIS SECTION – PROBATION USE ONLY	
Date Received:	*Received By:*
Date Fwd. to PO:	*Forwarded By:*
Date Fwd. to CM:	*Forwarded By:*

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Release of Information

Candidate's Name: _____

Date of Birth: _____

Social Security Number: _____-_____-_____

Address: _____

_____

I consent to Butler County Veterans Treatment Court Team to obtain complete health records (hospital records – including records relating to mental healthcare, verification of diagnoses, treatment providers, dates of counseling, level of participation in counseling, test results, evaluation, assessment of problems, date and nature of further assessments, progress reports).

The records are required for the specific purpose of: referral to other services, coordination of care, consultation with doctors, consultation with other mental health providers, and/or transfer of care.

This authorization is intended as a voluntary waiver of the privileged communication rule of law and is in compliance with Federal regulations (42 CRF, Section 2.39) and Pennsylvania statues. I have had this form read and explained to me and I understand its content.

I agree to unrestricted communication between providers and the Butler County Veterans Treatment Court Team, and I understand that I cannot revoke this consent until there has been a formal and effective termination or revocation of such release from confinement, probation or parole, pursuant with Federal regulation (CRF, Section 2.39, Paragraph c).

_____
Signature of Candidate

_____ _____
Witness **Date**

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 information needed 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 the provision of treatment, payment, enrollment in the VA Health Care Program, or eligibility for benefits on the signing of an authorization, except for research-related treatment where an authorization for the use or disclosure of individually-identifiable health information for such research is required. 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 24VA10A7 "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)*

Butler VA Health Care System
353 North Duffy Road
Butler PA 16001

LAST NAME- FIRST NAME- MIDDLE NAME	DATE OF BIRTH *(mm/dd/yyyy)*

PATIENT'S MAILING ADDRESS (*including City, State and Zip Code*)

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

Butler County Court of Common Pleas, Veterans Treatment Court, P.O. Box 1208, Butler, PA 16003-1208
Phone # 724 284-5292

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

☒ TREATMENT ☐ BENEFITS ☒ LEGAL ☐ EMPLOYMENT ☐ OTHER *(Please specify)* _____

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: _____

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

☒ LAB RESULTS:

- ☐ SPECIFIC TESTS *(Name & Date)*: _____
- ☒ DATE RANGE: all drug screens as deemed relevant by court/probation

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

☒ LIST OF ACTIVE MEDICATIONS: current list of active medications

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

☒ OTHER *(Describe)*: Verbal/copies of Diagnosis, treatment recommendations/progress, PAJCIS

LAST NAME- FIRST NAME- MIDDLE NAME	DATE OF BIRTH *(mm/dd/yyyy)*

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 *(select one of the following)*:

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

☐ ON *(mm/dd/yyyy)* _____ *(enter a future date other than date signed by patient)*

☒ UNDER THE FOLLOWING CONDITION(S): upon completion and/or discharge of the treatment court program and probation

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

VJO will provide summary of progress via written, verbal, telephone, fax, PAJCIS, and secure email that is required by court for monitoring of patient progress in treatment and compliance with legal conditions of Veterans Treatment Court participation, inclusive of all relevant medical record information both past and future.

DATE RELEASED *(mm/dd/yyyy)*	RELEASED BY: