Mental Health Court Screening Instructions for Private Attorneys

Step 1. Please complete the Mental Health Court Referral form (page 2, making sure to: a. include the signatures of your client *and* the assigned prosecutor/s. Electronic signatures or email approval suffice for signatures, b. include **all** cases you want to come into MHC, pre or post-plea) and email a copy of the referral to:

- Optum (Angie Zuehlke, angie.zuehlke@optum.com)
- District Attorney's Office (Jennifer Mitchell, email below, *and* Maggie Padilla at mjpadilla@slco.org)
- Mental Health Court Team, email: slccrimmh@utcourts.gov

Your application will be prioritized according to the date of receipt of the referral.

Step 2. Review and complete the Mental Health Court Intake/Screening Form (page 3) in detail with your client.

Step 3. Schedule a LSCMI assessment (see #1 on Page 3 on the below Mental Health Court Intake/Screening Packet below for further details/instruction).

Step 4. Have your client sign releases included in the Mental Health Court Intake Screening Packet (pages 4-6).

Step 5. Use your own releases, or the included Release of Information (page 7) and collect the records from the agencies where your client indicates they have been treated for mental health issues.

Step 6. Email completed Mental Health Court Intake/Screening Packet and all records gathered in Step 5 to Angie Zuehlke (and Angie Zuehlke only).

Mental Health Court screening is a lengthy process. Record collection is the longest part and can take upwards of 4-8 weeks for records to come in. Please advise your client of this. Once you send Angie Zuehlke the records, she will keep you updated on the progress of screening and will inform you of the final MHC screening decision.

For consultation on any clinical matters:

Angie Zuehlke
Optum Salt Lake County
Office: (385) 867-4647
Email: angie.zuehlke@optum.com

For consultation on any legal matters:

Jennifer Mitchell
District Attorney's Office
Office: (385) 468-7649
Email: jmitchell@slco.org

IN THE DISTRICT COURT OF THE THIRD JUDICIAL DISTRICT IN AND FOR SALT LAKE COUNTY, STATE OF UTAH	
THE STATE OF UTAH, **Plaintiff,** **vs.** **_____,** **Defendant.**	**MENTAL HEALTH COURT REFERAL** **Case No.**[1] **_____** **JUDGE** **_____**

I, _____, hereby request that the above-entitled case be screened for Mental Health Court. I also certify that I am a resident of Salt Lake County.

DATED this _____ day of _____, 2022.

_____
DEFENDANT

_____
PROSECUTING ATTORNEY
Bar No. _____

_____
ATTORNEY FOR DEFENDANT
Bar No. _____

[1] Include all active pending cases and active probation cases

MENTAL HEALTH COURT

INTAKE / SCREENING FORM

Attorney: _____ Prosecutor: _____

Full Name:	DOB:	SS#:
Is client a Veteran? ☐ Yes ☐ No.	Custody Status:	Phone Number:
Where will client be living if they are involved in MHC? (Specify if Homeless. Must live in Salt Lake County)		
Insurance? *Circle One* Medicare Medicaid Private Other:_____		
Is client legally competent? ☐ No. ☒ Yes. Proceed to next question.		
Does the client report a diagnosis of any of the following: ☐**Schizophrenia** ☐**Bipolar Disorder** ☐**Schizoaffective Disorder** ☐ No. This client **is not** eligible for Mental Health Court.		
Are there records verifying the above diagnosis? ☐ Yes. Identify each treating agency/Physician/MH Counselor listed below ☐ No. Schedule a private MH Evaluation with a provider		

☒ **ADC – SL County**	☐ **Jordan Valley Hosp**	☐ **SL Beh. Health Hosp**	☐ **Bear River MH**	☐ **Timpanogos Reg Hosp**
☐ **Alta View Hosp**	☐ **JV Hosp-WV / Pioneer**	☐ **SLRMC (Holy Cross)**	☐ **Cache Valley Hosp**	☐ **Wasatch Mental Health**
☐ **Cornerstone Coun**	☐ **St. Mark's Family Me**	☐ **Logan Regional**	☐ **SL Clinic- IHC**	☐ **4CornersComm Beh Health**
☐ **Criminal Just. Svcs**	☐ **LDS / Cottonwood**	☐ **St. Mark's Hospital**	☐ **McKay-Dee Hospital**	☐ **Central UT Counsel Ctr**
☐ **Granger Med Clinic**	☐ **Lone Peak Hosp**	☐ **Ogden Regional Hosp.**	☐ **Utah Valley Reg Hosp**	☐ **Northeastern Counsel Ctr**
☐ **4th Street Clinic**	☐ **Memorial InstaCare**	☐ **Weber Human Services**	☐ **San Jan Counseling Ctr**	☐ **Comm. Health Clinic**
☐ **ExodusHealth-WV**	☐ **Maliheh Clinic**	☐ **UNI (Huntsman MH Inst)**	☐ **Bountiful InstaCare**	☐ **SW Beh. Health Center**
☐ **ExodusHealth-Mag**	☐ **PolizziClinic / Impact MH**	☐ **U of U Medical Center**	☐ **Davis Behavioral Health**	☐ **Summit - Health U Ctr**
☐ **Intermtn Med Ctr**	☐ **Primary Children's**	☐ **U of U Greenwood Clinic**	☐ **Davis Community Hosp**	☐ **InstaCare_____**
☐ **Highland Ridge**	☐ **Riverton Med Center**	☐ **U of U Redwood**	☐ **Lakeview Hospital**	☐ **Social Worker_____**
☐ **Hopeful Beginnings**	☐ **Sequoia Counseling**	☐ **U of U Sugar House**	☐ **Layton Hospital**	☐ **Counselor_____**
☐ **Hunter Clinic**	☒ **Valley Beh. Health**	☐ **American Fork Hosp**	☐ **Utah State Hosp**	☐ **Dr. _____**
☐ **Jordan Meadows**	☐ **Social Security Admin**	☐ **VOA**	☐ **Orem Community Hosp**	☐ **Dr. _____**

1. All applicants must undergo a criminogenic risk assessment prior to being approved for MHC. Valley Behavioral Health will be administering the LSCMI during regular business hours at the number listed below. Valley will coordinate with the jail if the applicant is in custody. For all out-of-custody individuals, please contact: *Valley Behavioral Health (801) 536-6594*

2. Have you educated your client about the requirements of Mental Health Court?
   - ☐ A. Weekly court reviews (Tuesdays or Fridays)
   - ☐ B. Medication compliance
   - ☐ C. Applicants must reside in Salt Lake County.
   - ☐ D. No alcohol or illegal drug use[2]
   - ☐ E. Daily/weekly/monthly mandatory treatment
   - ☐ F. Random urinalysis
   - ☐ G. Must plead guilty
   - ☐ H. AP&P or CJS supervision
   - ☐ I. Probation length: Felony:36 months MA: 24 months, MB: 12 months.

3. Does your client understand all the requirements and choose to be involved in Mental Health Court?
   - ☐ No. This client is not eligible for Mental Health Court.
   - ☐ Yes. Proceed with MHC Application process

4. Case transfers to Mental Health Court require an open misdemeanor or felony case in 3rd District Court. Upon acceptance into Mental Health Court, Justice Court cases must be appealed to District Court to transfer the case to Mental Health Court.

5. The client must sign an Inter- Agency Release of Information for Screening, Optum Authorization for Release of Information, and the MHC Referral pleading which must be filed with the Mental Health Court clerk and emailed to the Mental Health Court Prosecutor.

6. Applicants must plead to a charge for inclusion in the program. The District Attorney's Office will determine whether the defendant receives a "plea in abeyance" or "condition of probation" offer.
   a. Referrals will be reviewed by the assigned prosecutor on the Applicant's case. If the assigned prosecutor denies referral, the Applicant can appeal the decision to the District Attorney's Mental Health Court team. The Mental Health Court prosecutors, along with their administrators, will review the application and consider collateral information from the defense before making a final referral decision.

[2] Some medications, including medical cannabis, are not allowed in Mental Health Court. Talk to your attorney for more details.

SALT LAKE THIRD DISTRICT COURT
INTER-AGENCY RELEASE OF INFORMATION FOR MENTAL HEALTH COURT SCREENING FORM

I, DOB:

authorize the release and disclosure of all records and information obtained by my attorney for the sole purposes of clinical and legal screening for the Third District Mental Health Court ("MHC"). Prior to my acceptance into MHC and the terms and conditions of MHC, these records and the information contained therein may not be used for any other purpose. Additionally, I authorize my attorney to provide access to my records and/or detailed summaries of those records to Angie Zuehlke, LCSW of Optum Salt Lake County and Jennifer Mitchell, Salt Lake County District Attorney's Office for the purpose of clinical and legal screening. No information obtained through this release or related screening may be shared with law enforcement agencies or be used for prosecutorial purposes.

This authorization applies to the following types of information, as indicated below:

- ☐ **Mental Health Diagnosis and Treatment**
- ☐ **Medical Diagnosis and Treatment**
- ☐ **Legal issues/ records**
- ☐ **Jail/ Custody data**
- ☐ **Alcohol & Drug Abuse Treatment** ***(Drug & Alcohol info is protected under Code of Federal Regulations, Title 42, Volume1, Part 2)***

I understand that my records may be confidential, depending on the information contained in them, under one or more of the following statutes or regulations:

☐ ***Medical Records (including mental health records) - Health Insurance Portability and Accountability Act of 1996 (HIPAA); 45 U.S.C. § 1320d et seq.; Part C and Privacy Rule; CFR, Title 45, Volume 65, Part 160-164.***

☐ ***Drug or Alcohol Treatment Records - CFR, Title 42, Volume 1, Part 2.***

I understand that medical records and drug and alcohol treatment records generally cannot be disclosed without my written consent. This authorization is valid for the duration of the court's supervision/ monitoring period in

Case(s) #:

I understand that all information and records collected may be discussed by all of the above agencies. I waive any durational limits that might otherwise apply to this release.

Signature of Client Date	Signature of Witness Date

12921 South Vista Station Blvd. STE 200
Draper, Utah 84020

Authorization for Release of Information

Member's Name _____ Date of Birth _____ ☐ Member or Subscriber ID# ☐ Chart #

Member's Street Address _____ City _____ State ___ Zip Code _____

Member's Phone Number _____

I understand that this authorization is voluntary. I understand that my health information may be protected by the Federal Rules for Privacy of Individually Identifiable Health Information (Title 45 of the Code of Federal Regulations, Parts 160 and 164), the Federal Rules for Confidentiality of Alcohol and Drug Abuse Patient Records (Title 42 of the Code of Federal Regulations, Chapter I, Part 2), and/or state laws. I understand that my health information may be subject to re-disclosure by the recipient and that if the organization or person authorized to receive the information is not a health plan or health care provider the information may no longer be protected by the Federal privacy regulations.

I understand that my health information may contain information created by other persons or entities including health care providers, and may also contain drug and alcohol, mental health, HIV/AIDS, psychotherapy, genetic, reproductive and sexually transmitted disease information. I further understand that by signing this document, I am authorizing the release or exchange of this information with the person or organization named below.

I understand that my health plan may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this form, except for certain eligibility or enrollment determinations prior to my enrollment in its health plan, and for health care that is solely for the purpose of creating protected health information for disclosure to a third party.

I understand that I may revoke this authorization at any time by notifying Optum in writing. However, the revocation will not have an effect on any actions Optum took before it received the revocation.

I authorize Optum to receive from or disclose my individually identifiable health information to the following person(s) or organization(s):

Name	Address	City, State, Zip	Phone
Third District Court	**450 South State Street**	**SLC, Utah 84114**	**801-238-7700**
Salt Lake County District Attorney	**35 East 500 South**	**SLC, Utah 84114**	**385-468-7700**
Salt Lake Legal Defender Association	**275 East 200 South**	**SLC, Utah 84114**	**801-532-5444**
Adult Probation and Parole	**36 Fremont Avenue**	**SLC, Utah 84101**	**801-239-2100**
Criminal Justice Services	**145 East 1300 South #501**	**SLC, Utah 84115**	**385-468-3500**
NAMI Utah	**1600 West 2200 South #202**	**WVC, Utah 84119**	**801-323-9900**

Salt Lake County Metro Jail	**3415 South 900 West**	**So. SL, Utah 84119**	**385-468-8400**
Name	Address	City, State, Zip	Phone
First Step House	**440 South 500 East**	**SLC, Utah 84102**	**801-359-8862**
Name	Address	City, State, Zip	Phone
Odyssey House	**344 East 100 South**	**SLC, Utah 84111**	**801-322-3222**
Name	Address	City, Utah, Zip	Phone
Valley Behavioral Health	**4460 Highland Drive #100**	**SLC, Utah 84124**	**888-949-4864**
Name	Address	City, State, Zip	Phone
Volunteers of America	**435 W. Bearcat Drive**	**So. SL, Utah 84115**	**801-363-9414**
Name	Address	City, State, Zip	Phone

Other:_____

Description of individually identifiable health information to be received or disclosed (check appropriate type(s) of information):

- ■ All
- ☐ Progress Reports
- ☐ Eligibility/Benefits
- ☐ Information used to make benefit determinations
- ☐ All pertinent information Optum Health deems appropriate for the purpose checked below
- ☐ Other (describe): _____

The purpose of this authorization is (check all that apply):

- ☐ To allow the appropriate management of treatment, services, and/or coverage under the member's benefit plan.
- ☐ Benefit Management
- ■ Other (describe): Coordination of care during participation in 3rd District Mental Health Court

The dates of records to be disclosed:

From: acceptance into Mental Health Court To: end of participation in Mental Health Court

THE MEMBER OR MEMBER'S REPRESENTATIVE MUST COMPLETE THE REST OF THIS FORM:

I understand that this authorization will expire:

- ☐ On _____ (MM/DD/YYYY) or one year from the date of the signature below (or as set forth in the applicable state-specific provisions below).

OR

- ■ Once the following event occurs (***does not apply to Illinois residents***):
  end of participation in the Mental Health Court program

_____

Member's Signature Date

_____ _____

Member's Printed Name Date

HIPAA COMPLIANT

AUTHORIZATION FOR RELEASE OF INFORMATION

TO: **NAME:** **DOB:** **SSN:**	This instrument authorizes you to furnish and release to the:

This instrument authorizes you to furnish and release to _____ or a representative thereof, **for the purpose of legal representation,** all of my records, including those normally considered private, privileged, confidential, controlled and protected, including but not limited to: medical, psychiatric, and hospital records; psychological, mental health, and substance abuse records; court records or any records incidental thereto; military testing reports or medical evaluations and reports; and medical, psychiatric, psychological testing, assessments, evaluations, diagnoses, findings, treatments, care plans and reviews, referrals, admissions and discharges, and opinions in your records on the following:

__X__ HOSPITAL / ER / CRISIS EVALUATIONS	__X__ MEDICATION / PRESCRIPTION HISTORY
__X__ MEDICAL DIAGNOSTIC / TREATMENT	__X__ LAB / DRUG TESTING RECORDS
__X__ PSYCHOLOGICAL / PSYCHIATRIC	__X__ GROUP THERAPY / PSYCHOEDUCATIONAL
__X__ DRUG & ALCOHOL ABUSE / TREATMENT	__X__ CASE MANAGEMENT / TREATMENT PLANS & REVIEWS
_____ EDUCATIONAL / TRANSCRIPT / IEP	_____ EMPLOYMENT RECORDS
_____ VERBAL COMMUNICATION	_____ CIVIL / CRIMINAL COURT RECORDS
__X__ OTHER: _____	

I understand that my records may be confidential, depending on the information contained in them, under one or more of the following statues or regulations:

- **Medical Records (including mental health records) – Health Insurance Portability and Accountability Act of 1996 (HIPAA); 45 U.S.C. 1320d et seq.; Part C and Privacy Rule; CFR, Title 45, Volume 65, Part 160-164.**
- **Drug or Alcohol Treatment Records – CFR, Title 42, Volume 1, Part 2.**

PROHIBITION ON REDISCLOSURE: Alcohol and Drug Abuse Medical Records are protected by Federal confidentiality rules (42 CFR Chap. 1, Part 2, Subpart C § 2.32) The Federal Rules prohibit further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Chap. 1, Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I understand that authorizing the disclosure of this health information is voluntary. I understand that any disclosure of information, carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have any questions about disclosure of my health information, I can contact the authorized individual or organization making the disclosure. I understand that the information authorized for release may indicate the presence of a communicable or venereal disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, or the human immunodeficiency virus, also known as acquired immune deficiency syndrome (AIDS). This document specifically authorizes the release of mental health, substance abuse, psychological, and psychiatric information and records. With this knowledge, I give my consent to the release of all information in my medical and other records as indicated above, including any information concerning my identity, and release the above agency / health provider, its affiliates, agents and employees, from any liability in connection with the release of the information contained herein. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Medical Record Department and /or Privacy Officer. I understand that the revocation will not apply to information that has already been released in response to this authorization. The medical provider to whom this authorization is furnished may not condition treatment on whether or not I sign the authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire 365 days from the date signed. Notarized photocopies of this authorization are to be given the same effect as the original.

DATE: _____

X _____
Client Signature

STATE OF UTAH)
:SS
COUNTY OF SALT LAKE)

On the _____ day of _____, 2022
before me, _____, a notary public,
personally appear _____ proved on the basis of satisfactory
evidence to be the person whose name is subscribed to this instrument, and
acknowledged he/she executed the same.

*** Copy Given to Client: Yes_____ Declined_____**

X _____
Notary Signature