

## Mental Health Court Screening Instructions for Private Counsel

- 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](mailto:angie.zuehlke@optum.com))
  - District Attorney's Office (Jennifer Mitchell at [jmitchell@slco.org](mailto:jmitchell@slco.org) and Maggie Padilla at [DA-SpecialtyCourts@slco.org](mailto:DA-SpecialtyCourts@slco.org))
  - Mental Health Court Team, email: [slccrimmh@utcourts.gov](mailto:slccrimmh@utcourts.gov)

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

- Step 2. Review, complete and have your client sign where indicated, the Mental Health Court Screening Form, the Inter-agency Release of Information for MHC Screening and the Optum Release of Information. Email the completed forms (so, in total, pages 3 to 6) to Angie Zuehlke, Jennifer Mitchell and Maggie Padilla.

- Step 3. Schedule a RANT assessment (see #1 on the MHC Screening form (page 3) for further details/instruction on how to set that up).

- Step 4. Use your own HIPPA releases, or the included Authorization for 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 5. Email all records gathered in Step 4 to Angie Zuehlke (and Angie Zuehlke only).

*Mental Health Court screening is a lengthy process. Record collection is the longest part and it 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 posted on the progress of screening.*

For consultation on any clinical matters:

Angie Zuehlke  
Optum Salt Lake County  
Cell: (801) 673-5384  
Email: [angie.zuehlke@optum.com](mailto:angie.zuehlke@optum.com)

For consultation on any legal matters:

Jennifer Mitchell  
Salt Lake County District Attorney's Office  
Office: (385) 468-7649  
Email: [jmitchell@slco.org](mailto:jmitchell@slco.org)

(last update 5/29/24)

**IN THE DISTRICT COURT OF THE THIRD JUDICIAL DISTRICT  
IN AND FOR SALT LAKE COUNTY, STATE OF UTAH**

<p><b>THE STATE OF UTAH,</b></p> <p style="text-align: center;"><b>Plaintiff,</b></p> <p><b>vs.</b></p> <p>_____,'</p> <p style="text-align: center;"><b>Defendant.</b></p>	<p style="text-align: center;"><b>MENTAL HEALTH COURT REFERRAL</b></p> <p><b>Case No.</b><sup>1</sup> _____</p> <p><b>JUDGE</b> _____</p>
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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 \_\_\_\_\_, 20\_\_.

\_\_\_\_\_  
DEFENDANT

\_\_\_\_\_  
PROSECUTING ATTORNEY  
Bar No. \_\_\_\_\_

\_\_\_\_\_  
ATTORNEY FOR DEFENDANT  
Bar No. \_\_\_\_\_

<sup>1</sup> Include all active pending cases and active probation cases

## MENTAL HEALTH COURT SCREENING FORM

Attorney: \_\_\_\_\_ Prosecutor: \_\_\_\_\_

Full Name:	DOB:	SS#:
Is client a Veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No.	Custody Status:	Phone Number:
Where will client be living if they are involved in MHC? (Specify if Homeless. <b>Must live in Salt Lake County</b> )		
Insurance? <i>Circle all that apply.</i> Medicaid                      Medicare                      None                      Private Policy		
<b>Please note – clients with Medicare only and most private policies may make it cost prohibitive to participate in MHC. Our Clinical Director will discuss funding with client.</b>		
Your Client must be legally competent to participate in MHC. If competency is being questioned, do not proceed with MHC screening.		
Your client must report a diagnose of one of the following to proceed with a Mental Health Court screening: (please select) <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Bipolar Disorder <input type="checkbox"/> Schizoaffective Disorder		
Your client must meet criteria for Serious Mental Illness (SMI) to qualify for MHC– to be determined by Clinical Director at time of clinical screening.		
<b>DEFENSE COUNSEL is responsible for collecting mental health records. Below is a list of potential agencies where your client may have been treated. Please discuss and collect pertinent records from any and all sources, including ones not listed below.</b>		

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Salt Lake County Jail – ADC/Oxbow  | <input type="checkbox"/> 4 <sup>th</sup> Street Clinic | <input type="checkbox"/> Cornerstone Counseling Center                            |
| <input type="checkbox"/> Odyssey House -including FACT team | <input type="checkbox"/> Valley Behavioral Health      | <input type="checkbox"/> Volunteers of America – including ACT Team               |
| <input type="checkbox"/> Utah State Hospital                | <input type="checkbox"/> Clinical Consultants          | <input type="checkbox"/> New Roads  |
| <input type="checkbox"/> Private Therapist                  | <input type="checkbox"/> Private Psychiatrist          | <input type="checkbox"/> Primary care physician providing psychiatric medications |
| <input type="checkbox"/> UNI – (Huntsman MH Institute)      | <input type="checkbox"/> St. Mark’s Hospital           | <input type="checkbox"/> University of Utah Hospital                              |
| <input type="checkbox"/> Salt Lake Behavioral Health        | <input type="checkbox"/> McKay-Dee Hospital            | <input type="checkbox"/> Holy Cross/Jordan Valley West Hospital (in WVC)          |

1. All applicants must undergo a criminogenic risk assessment (we use the RANT) prior to being approved for MHC. Valley Behavioral Health will be administering the RANT. Valley will meet with clients in jail if the applicant is in custody. For all out-of-custody individuals, please ask your client to contact: Valley Behavioral Health 801-456-4533 to complete the RANT over the phone.
2. Please educated your client about the requirements of Mental Health Court. They include;
 

<input type="checkbox"/> A. Weekly court attendance (Tuesdays or Fridays)	<input type="checkbox"/> F. Weekly random drug testing
<input type="checkbox"/> B. Medication compliance	<input type="checkbox"/> G. Must plead guilty
<input type="checkbox"/> C. Applicants <u>must</u> reside in Salt Lake County.	<input type="checkbox"/> H. AP&P Supervision
<input type="checkbox"/> D. No alcohol, illegal or non-prescribed drug use <sup>2</sup>	<input type="checkbox"/> I. Probation length: Felony:36 months
<input type="checkbox"/> E. Daily/weekly/monthly mandatory treatment	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 3<sup>rd</sup> 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. 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.

<sup>2</sup> Some medications, including medical cannabis, are not allowed in Mental Health Court.





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):**

<b>Third District Court</b>	<b>450 South State Street</b>	<b>SLC, Utah 84114</b>	<b>801-238-7700</b>
Name	Address	City, State, Zip	Phone
<b>Salt Lake County District Attorney</b>	<b>35 East 500 South</b>	<b>SLC, Utah 84114</b>	<b>385-468-7700</b>
Name	Address	City, State, Zip	Phone
<b>Salt Lake Legal Defender Association</b>	<b>275 East 200 South</b>	<b>SLC, Utah 84114</b>	<b>801-532-5444</b>
Name	Address	City, State, Zip	Phone
<b>Adult Probation and Parole</b>	<b>36 Fremont Avenue</b>	<b>SLC, Utah 84101</b>	<b>801-239-2100</b>
Name	Address	City, State, Zip	Phone
<b>Salt Lake County Jail</b>	<b>3415 South 900 West</b>	<b>So. SL, Utah 84119</b>	<b>385-468-8400</b>
Name	Address	City, State, Zip	Phone
<b>First Step House</b>	<b>440 South 500 East</b>	<b>SLC, Utah 84102</b>	<b>801-359-8862</b>
Name	Address	City, State, Zip	Phone

<b>Odyssey House</b>	<b>344 East 100 South</b>	<b>SLC, Utah 84111</b>	<b>801-322-3222</b>
Name	Address	City, Utah, Zip	Phone
<b>Valley Behavioral Health</b>	<b>4460 Highland Drive</b>	<b>SLC, Utah 84124</b>	<b>888-949-4864</b>
Name	Address	City, State, Zip	Phone
<b>Volunteers of America/Cornerstone</b>	<b>1875 S. Redwood Road</b>	<b>SLC, Utah 84104</b>	<b>801-363-9414</b>
Name	Address	City, State, Zip	Phone
<b>NAMI Utah</b>	<b>1600 West 2200 South</b>	<b>WVC, Utah 84119</b>	<b>801-323-9900</b>
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 3<sup>rd</sup> 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 \_\_\_\_\_

## AUTHORIZATION FOR RELEASE OF INFORMATION

<b>TO:</b>  <b>NAME:</b> <b>DOB:</b> <b>SSN:</b>	This instrument authorizes you to furnish and release to the:
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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:

- |  |   |
|--|---|
| <input checked="" type="checkbox"/> HOSPITAL / ER / CRISIS EVALUATIONS | <input checked="" type="checkbox"/> MEDICATION / PRESCRIPTION HISTORY           |
| <input checked="" type="checkbox"/> MEDICAL DIAGNOSTIC / TREATMENT     | <input checked="" type="checkbox"/> LAB / DRUG TESTING RECORDS                  |
| <input checked="" type="checkbox"/> PSYCHOLOGICAL / PSYCHIATRIC        | <input checked="" type="checkbox"/> GROUP THERAPY / PSYCHOEDUCATIONAL           |
| <input checked="" type="checkbox"/> DRUG & ALCOHOL ABUSE / TREATMENT   | <input checked="" type="checkbox"/> CASE MANAGEMENT / TREATMENT PLANS & REVIEWS |
| <input type="checkbox"/> EDUCATIONAL / TRANSCRIPT / IEP                | <input type="checkbox"/> EMPLOYMENT RECORDS                                     |
| <input type="checkbox"/> VERBAL COMMUNICATION                          | <input type="checkbox"/> CIVIL / CRIMINAL COURT RECORDS                         |
| <input checked="" type="checkbox"/> OTHER: _____                       |   |

**I understand that my records may be confidential, depending on the information contained in them, under one or more of the following statuses 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.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date