KENOSHA COUNTY TREATMENT COURT PETITION

After completing this Petition please forward directly to:

Brian Bynsdorp
Treatment Court Coordinator
Kenosha County Division of Aging, Disability & Behavioral Health Services
8600 Sheridan Road, Kenosha, WI 53143
262-605-6608
262-605-6649 fax
Brian.Bynsdorp@kenoshacounty.org

You may forward by fax or email. Please email any questions.

Treatment Court Eligibility:

1. Must be 18 or older and plan to live in Kenosha County during program participation.
2. Diagnosed with mental health and/or substance use disorder.
3. Past or present conviction(s) must not be sexually assaultive in nature.
4. Convicted of or current charges of non-violent crimes.
5. Individuals with charges or convictions of Delivery of Drugs do not qualify, however there are exceptions that will be considered case by case.
6. Must voluntarily agree to abide by the Treatment Court Rules (see Participation Agreement).
7. Must be facing a minimum of 2 or more years at sentencing.
8. Alternatives to Revocation and Deferred Prosecution Agreements are considered case by case.
9. Prospective participants officially accepted into Treatment Court have 30 days, from notification of their official acceptance, to indicate acceptance by scheduling a plea hearing. If a prospective participant fails to indicate acceptance within 30 days, they may be required to re-apply to Treatment Court. The final plea/sentencing shall occur within 60 days of being notified of their acceptance into Treatment Court, unless otherwise agreed to by the Assistant District Attorney.

* This is not an OWI court. If the sole charge you are referring someone on is for an alcohol related OWI, they will not be considered.

** **<u>Defense Attorney/Probation Agents</u>: You must review Participation Agreement and fill out Release of Information with your client/offender and send in with this petition to be considered.**

ALL SECTIONS MUST BE COMPLETED FOR CONSIDERATION

Date_____ Applicant name _____

DOB _____ M _____F _____

Race/ethnicity _____Primary language _____

Phone_____ Email _____

Address _____

(Must be Kenosha County resident and plan to reside in Kenosha County upon release)

Referring Attorney/Agent name _____ Phone _____

Attorney/Agent email _____

Currently incarcerated?_____YES_____NO If Yes, where?_____KCJ _____ KCDC _____Other

DOC status (if on probation, current agent ***must*** agree with Attorney's referral to Treatment Court):

_____

Current charge(s) and case #(s):

_____

_____

_____

Defendant acknowledges he/she has/may have a substance use disorder?_____ YES _____ NO

Treatment provider(s) _____

Mental health diagnosis (if applicable)

_____

_____

_____

Treating Psychiatrist _____Location _____

RECENT CRIMINAL HISTORY/PROBATION VIOLATIONS

Offense(s)	**Disposition**	**Date**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I,_____, hereby authorize the disclosure of records and information regarding:

Participant name_____ Phone _____

Participant address _____ Date of birth_____

BETWEEN

- Kenosha County Treatment Court Team, 912-56th St., Kenosha, WI 53140
- Kenosha County Division of Aging, Disability & Behavioral Health Services, 8600 Sheridan Rd, Kenosha, WI 53143

AND

- All KHDS Programs under contract with Kenosha County Division of Aging, Disability & Behavioral Health Services
- Wisconsin Department of Corrections, 1567- 19th Avenue Kenosha, WI 53140
- Oakwood Clinical Associates, 4109 67th St, Kenosha, WI 53142
- Professional Services Group, 6233 39th Ave., Kenosha, WI 53142

The disclosure of the following specific information is authorized:

☐ Psychosocial History
☐ Psychiatric Evaluation
☐ Psychological Evaluation
☐ Treatment Planning
☐ Treatment Notes
☐ Physician's Orders
☐ Discharge Summary
☐ Lab Data (X-ray & Laboratory)
☐ Treatment Schedule
☐ Alcohol & Drug Abuse Records
☐ Medication Examination & Services Rendered
☐ Information from Other Agencies (re-release)
☐ Other (specify) _____

This information may be released for the purpose of on-going case management/professional referral and is necessary for the purpose stated. This authorization shall expire when no longer necessary to effectuate the purpose for which it is given, but no later than (one year of today's signature) _____

_____ _____
Participant Signature Date

_____ _____
Coordinator/Attorney/Witness Signature Date

NOTE: *This consent is subject to revocation at any time by me in writing, except to the extent that action has been taken in reliance thereon.*

The following notice shall accompany all disclosed information regarding drug and alcohol abuse clients. "This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulations (42CFR, Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose."

The patient has the right of access to medical record information as provided under SS HSS92.05 and 92.06.