TACOMA COMMUNITY COURT

REFERRAL TO COMMUNITY COURT

Thank you for your interest in Tacoma Community Court
Please complete both sides of referral form and submit:

Tacoma Municipal Therapeutic Court
930 Tacoma Avenue S Room 841
Tacoma, WA 98402
Email: tmtc@cityoftacoma.org or **Fax:** (253) 573-2511

Date of Referral: _____ **Referred by:** _____

Full Legal Name: _____

Previous Name(s): _____

Case Information

Case Number(s)/Charge(s): _____

Defense Attorney Name/WSBA #: _____

Phone: _____ **Email:** _____ **Pending Felony** _____

Personal Information

Date of Birth: _____ **Marital Status:** _____

Address: _____

Phone Number(s): Primary: _____ **Secondary:** _____

Email: _____

Support Person Name and Number (if available): _____

History of Military Service: ☐ Yes ☐ No **Social Security Benefits:** ☐ Yes ☐ No

Medical Insurance: ☐ Yes ☐ No If yes, what type: _____

Equity and Inclusion Statistics

The information provided in this section is for program monitoring purposes only. Answers provided will not affect acceptance determination.

Preferred Name: _____ **Pronouns:** ☐ He / ☐ She / ☐ They

Race:

☐ American Indian or Alaska Native
☐ Black or African American
☐ Chinese
☐ Filipino
☐ Hispanic, Latino, or Spanish origin
☐ Japanese
☐ Korean
☐ Middle Eastern or North African
☐ Native Hawaiian or Other Pacific Islander
☐ Vietnamese
☐ White
☐ Multi-racial
☐ Some other race or origin
☐ Unknown
☐ Prefer not to answer

Gender:

☐ Male
☐ Female
☐ Non-Binary
☐ Trans Man
☐ Trans Woman
☐ Prefer to self-describe
☐ Prefer not to answer

Sexual Orientation:

☐ Asexual
☐ Bisexual
☐ Heterosexual
☐ Homosexual
☐ Prefer not to answer

Ethnicity:

☐ Hispanic
☐ Non-Hispanic
☐ Unknown/Unreported
☐ Prefer not to answer

Do you have any disabilities or conditions that require special accommodation?

☐ Yes
☐ No

If yes, what is your disability or condition:

_____
_____

What accommodations are needed:

_____
_____
_____

Highest Level of Education Achieved: _____

Primary Spoken Language: _____ **Second Spoken Language:** _____

Is an Interpreter Needed: ☐ Yes ☐ No **If Yes, Language:** _____

Please attach the following documentation:
Signed Community Court Referral Consent for Mutual Exchange of Information
Signed Community Court Referral Consent for Release of Confidential Information

Thank you for your referral.
Please contact the Tacoma Municipal Therapeutic Court Team at (253)591-5229 or tmtc@cityoftacoma.org with any questions.

TACOMA COMMUNITY COURT

COMMUNITY COURT REFERRAL
CONSENT FOR MUTUAL EXCHANGE OF INFORMATION

I, _____, (DOB) _____ hereby consent to the mutual exchange of information (verbal and written) between the Tacoma Municipal Community Court Team Members regarding Case # _____:

This includes the following participants:

- Community Court Judge
- Assigned Prosecuting Attorney
- Assigned Defense Attorney
- Therapeutic Courts Coordinator
- Community Justice Counselor
- Pierce County Alliance
- Jail Mental Health
- Jail Transition Services
- Other: _____
- Other: _____

The purpose for disclosure is to provide information for Community Court Program eligibility consideration.

The extent of information to be disclosed includes medical, mental health, and substance use disorder assessment, evaluation, diagnosis, diagnosis, treatment, and discharge information. I understand that any information obtained by this release will be used solely to determine eligibility for the Community Court program and will remain confidential between Community Court team members.

I consent to the release of information relating to the above parties regarding any mental health and alcohol and/or drug use assessment and treatment _____(Initial)

Any new information shall not be utilized by the Prosecuting Attorney for any prosecution but may be considered by the Court in deciding my level of participation in or removal from the program.

I understand I may revoke this authorization at any time by providing 14-day advance written notice to:

Tacoma Municipal Therapeutic Court
930 Tacoma Ave S Room 841 Tacoma, WA 98402
Email: tmtc@cityoftacoma.org or Fax: (253) 573-2511

This authorization will expire 120 days from date of signature or upon Community Court Program admission or denial, whichever occurs sooner.

Signature: _____ **Date:** _____

RESTRICTION ON REDISCLOSURE AND USE: Pursuant to Part 2 of Title 42 of the Code of Federal Regulations, recipients of any information relating to Substance Use Disorder treatment records may only re-disclose it in connection with their official duties.

TACOMA COMMUNITY COURT

COMMUNITY COURT REFERRAL
CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____, hereby consent and authorize _____
to release/exchange the information specified to the Community Court Team including:

- Community Court Judge
- Assigned Prosecuting Attorney
- Assigned Defense Attorney
- Therapeutic Courts Coordinator
- Community Justice Counselor
- Jail Mental Health
- Jail Transition Services
- Other: _____
- Other: _____

Initial all information that applies:

_____ All Records
_____ Mental health assessment, evaluation, diagnosis, treatment recommendations, progress notes, and discharge information
_____ Substance use assessment, evaluation, diagnosis, treatment recommendations, progress notes, and discharge information
_____ Summary of mental health and substance use disorder treatment attendance and engagement
_____ Urinalysis and other drug and alcohol testing results
_____ Medical and medication (including psychiatric medication)
_____ Scheduling and appointment verification
_____ Other: _____

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