City of Tacoma Municipal Court

930 Tacoma Ave S Room 841 | Tacoma, WA 98402-2181
(253) 591-5229 | Fax (253) 573-2511 | www.cityoftacoma.org

REFERRAL TO MENTAL HEALTH COURT

Thank you for your interest in Tacoma Mental Health 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

Any referrals that take longer than 90 days to gather information will be closed and must be resubmitted for consideration.

Date of Referral: ________________ Referred By *(Name/Agency)*:____________________________

Full Legal Name: ____

Previous Name(s): ____

Case Information

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

Defense Attorney Name/WSBA #:____

Phone:______________________ Email: ______________________________

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: _______________________________________

Previous 10.77 Completed: ☐ Yes ☐ No Do you have a pending Felony: _____________________

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 Mental Health Court Referral Consent for Mutual Exchange of Information
Signed Mental Health Court Referral Consent for Release of Information
A copy of professional Mental Health Evaluation documenting mental health diagnoses (if available)

Thank you for your referral.

Please contact the Tacoma Municipal Therapeutic Court Team at
(253) 591-5229 or TMTC@cityoftacoma.org with any questions.

City of Tacoma Municipal Court

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Mental Health Court Referral
Consent for Mutual Exchange of Information

Case(s) #______________________
____

I, ____________________________, (DOB)____________hereby consent to the mutual exchange of information (verbal and written) between the Tacoma Municipal Mental Health Court Team Members.

This includes the following participants:

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

The purpose for disclosure is for Mental Health Court eligibility consideration only.

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 Therapeutic Court program and will remain confidential between Therapeutic Court team members.

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

Any new information may be considered by the Court in deciding my level of participation in or termination 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
Or via Fax: (253) 573-2511

I also understand that revocation of this consent may put me in breach of Mental health Court conditions of participation and, as such, may result in my case being returned to court for further proceedings.

This authorization will expire 120 days from date of signature or upon Mental Health Court admission/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 alcohol and/or drug treatment records may only re-disclose it in connection with their official duties.

City of Tacoma Municipal Court

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Mental Health Court Referral
Consent for Release of Confidential Information

Name: ____ Date of Birth: _________________

Address: ____ Phone: ____________________

____

I request and authorize ____
to release/exchange the information specified below to the City of Tacoma Municipal Mental Health Court Team including:

-Tacoma Municipal Court
-City of Tacoma Prosecutor's Office
-Department of Assigned Counsel
-Other Defense Counsel
-Pierce County Jail Mental Health Department
-Jail Transition Services

Initial all information that applies:

_______ 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: ____

_______ Other: ____

The purpose for disclosure is to provide information for Mental Health Court eligibility consideration.

I understand that 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
Or via Fax: (253) 573-2511.

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

Signature: ____ Date: __________________

Printed Name: ____________________________________

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