

IN THE _____ COURT OF MADISON COUNTY, ALABAMA
STATE OF ALABAMA

v.

CASE NO.: _____

_____, Defendant

**REQUEST BY DEFENDANT TO ENROLL IN THE
MENTAL HEALTH COURT PROGRAM**

Having been charged with the criminal offense(s) of _____, and believing that I may qualify to enroll in the Mental Health Court program in lieu of prosecution, I hereby apply for referral of my case(s) to the Mental Health Court program.

I understand that the Mental Health Court program is a diversion program designed to address potential mental health issues that may have played a part in my becoming involved in the above listed incident. Mental Health Court is not a way for me to escape responsibility for my actions, but instead to address them in an appropriate forum, and my criminal charges will only be dismissed upon a successful completion of the Mental Health Court Program.

Should I be approved for enrollment in the program, I understand that I will be required to work with the staff at Wellstone, Inc., and/or some other approved mental health provider to address various problems and issues that I may be facing. I also understand that I will be required to appear before the Judge presiding over the Mental Health Court program at regular intervals where inquiry will be made into my level of participation and progress within the program.

I further understand that I am required to maintain my residence in Madison County, Alabama, while enrolled in this program. Failure to do so would result in my removal from the program.

Because mental health issues are wide ranging and complex, I understand that there is no set time limit on my participation in this program. I realize that I will only be released from the program when the Judge, the Prosecutor, and the case manager agree that I have made sufficient progress in addressing the mental health issues in my life.

I further understand that my appearances before the Judge will be in open court at a docket designed for other Mental Health Court participants and that general information about my participation, my history, and my treatment may be discussed in that setting. Of course, every effort will be made to avoid discussion of extremely private, embarrassing, or sensitive information in that forum.

I further understand that I am requesting to participate in the Mental Health Court program to address my mental health issues not to avoid dealing with issue of drug usage or dependence. I understand that drug or alcohol usage while involved in this program would interfere with the actual medications prescribed to treat my mental health issues. Therefore, I understand that usage of narcotics (including methadone or suboxone) or alcohol while in this program may result in my dismissal from the program and imposition of the original sentence.

In order to participate in the program, I will have to:

- (1) Meet all eligibility requirements, including fully completing this application;
- (2) Plead guilty to the underlying charges;
- (3) Be sentenced on that charge, the execution of that sentence withheld until the successful completion or termination from the program;
- (4) Make a full disclosure concerning the involvement in the crime(s) I have been charged with;
- (5) Give permission to Wellstone, Inc., its affiliates and/or my private providers to release any pertinent information to the Judge, the Prosecutor, and any other agent or official designated by the Court that may relate to my participation in the program, even if this information would normally be protected by privacy rules or regulations.
- (6) Attend court as required by the Judge;
- (7) Attend all doctor's appointments and appointments with therapists;
- (8) Cooperate fully with Mental Health Center liaisons to Mental Health Court, including case managers and social workers;
- (9) Comply with all Mental Health Court Rules including abstaining from all narcotics (including suboxone and methadone) and alcohol.
- (10) Reside in Madison County, Alabama.

IT IS ALSO UNDERSTOOD THAT INFORMATION PROVIDED DURING A MENTAL HEALTH COURT PROCEEDING OR IN THE COURSE OF TREATMENT MAY NOT BE USED AGAINST THE DEFENDANT IN SUBSEQUENT CRIMINAL ACTIONS.

RELEASE: I have read and understand the above information and agree with the above cited rules and policies. I also hereby give permission to the entities involved in the Mental Health Court program, including the Judge, the Prosecutor, my Defense Attorney, the staff of the Wellstone, Inc., its associates, my private physician and/or psychiatrist, counselor, any probation officer or other official, and my attorney to disclose and discuss relevant information about me as it pertains to my participation in this program. I understand that this information may include otherwise private information regarding my diagnosis, treatment, criminal history, and the like.

DEFENDANT

The Defendant read, acknowledged and signed the above statement in the presence of the undersigned Defendant's attorney and/or the prosecutor, this the _____ day of _____, 20____.

DEFENDANT'S ATTORNEY

PROSECUTOR

Defendant is approved for mental health court enrollment on this the _____ day of _____, 2024.

PATRICIA DUNN DEMOS
MENTAL HEALTH COURT JUDGE

There is a deficiency in the application and notice has been sent: _____

Application received by Mental Health Court Staff: _____

STATEMENT IN SUPPORT OF ENROLLMENT

The following is a statement in my own words concerning the events that led to my arrest on the current charge:

[illegible]

The following is a list of medications that I am currently taking or have taken in the recent past:

[illegible]

Have you been diagnosed with any type of mental health issues in the past?

If so, what was the diagnosis? _____

Were any medications prescribed? _____ If so list all medications _____

.....

How long ago was that diagnosis made?

Who made the diagnosis? _____

Are you currently under the care of a mental health professional?

If so, who is your doctor/therapist, including name, address and telephone number. _____

RULES FOR ENROLLMENT AND PARTICIPATION

- I understand that I must fully qualify for the program and that determination will be made only after I have been assessed by an associate of Wellstone, Inc., and/or private psychiatrist, a copy of my assessment provided to the Court and approved by the Court for participation. _____
- I understand that admission to the Mental Health Court Program is within the discretion of the Court. _____
- I understand that if I am accepted into the program, I must complete all mandates of the program, and that if I fail to do so, I will be terminated from the program and my original sentence imposed. _____
- I understand that enrolling in the Mental Health Court will not absolve me of the responsibility for my actions, and that I will still be financially liable to any victim(s) in cases where the Court may order me to pay restitution. If required by the nature of my case, I may be required to pay restitution while I am participating in the program. _____
- I understand that I must submit to urinalysis for testing UPON REQUEST of the Court. A refusal or failure to provide a urinalysis will be viewed by the Court as a positive test result and sanctions will be imposed. If a test is altered in ANY form you will automatically be terminated. _____
- I understand that I am not allowed to use (whether prescribed or not) narcotic medications **and/or methadone and suboxone or any substance containing THC** while participating in this program. If I am currently prescribed these medications I agree to participate in a substance abuse treatment program and color code when placed in Mental Health Court. If I am not going to stop using these medications, I understand it is my responsibility to provide a letter from the prescriber stating (1) why it is prescribed and (2) that there is no non-narcotic alternative treatment. The letter must be submitted with this application for consideration by the Court. _____
- I understand that I must take any and all medications as prescribed for me by the Wellstone, Inc., or private psychiatrist and attend all counseling and treatment as recommended. _____
- I understand that I must sign all authorizations for release of information requested by the Court, treatment provider(s) and other resource providers. _____

RULES FOR ENROLLMENT AND PARTICIPATION (contd.)

- I understand that if I am treated by a private psychiatrist and/or counselor, it is my responsibility to ensure that the Court is given monthly verification of ongoing treatment and status reports from my mental health providers. _____
- I understand that if I successfully complete the program, the charges that brought me before the Court will be “Nolle Prossed,” but that I will have to pay the costs of court, and those costs will include the cost of any court appointed attorney who may have assisted me prior to my referral to the program. _____
- I understand that if I do not show up to Mental Health Court on the designated dates and have not made appropriate arrangements prior to that date, I will be dropped from the program and my original sentence imposed. _____
- I acknowledge that the contact information provided below is true and accurate and that it is my responsibility to inform the Court of any changes in that information. _____
- **I understand that this packet is an application for acceptance into the Mental Health Court and that a determination of acceptance has not been made at this time.** _____
- **I further understand that if accepted into the program, I, or my attorney, will receive an Order from the Court advising of my acceptance and given further instructions and a beginning court date.** _____
- If an emergency arises and I cannot make it to court on the required date, I will make contact with the Court at (256) 532-3636 to make other arrangements. I understand that regardless of the circumstances more than 2 absences, **excused or otherwise**, will result in my removal from the program. _____
- I understand any questions concerning this application should be directed towards my attorney or the Madison County District Attorney’s Office at (256) 532-3460. _____

DATE _____

DEFENDANT _____ DOB: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP _____

PHONE: _____ ALTERNATE NUMBER: _____

RETURN COMPLETED APPLICATION DIRECTLY TO THE OFFICE OF JUDGE DEMOS. APPLICATIONS ARE NOT TO BE SUBMITTED BY ELECTROIC FILING. THE APPLICATIONS ARE NOT TO BE PUBLISHED IN ANY PUBLIC RECORD. THE ATTORNEYS WILL RECEIVE EMAIL NOTICE OF ANY DEFICIENCIES. IT IS THE RESPONSIBILITY OF THE ATTORNEY AND THEIR CLIENT TO ADDRESS ANY DEFICIENCIES WITHIN 30 DAYS OF RECEIPT OF NOTICE.

**AGREEMENT TO AND AUTHORIZATION FOR
RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA**

Date: _____

PATIENT _____ **CASE NUMBER** _____

I am requesting to be considered for and to participate in a Madison County Mental Health Court Program which is overseen by the Mental Health Court Judge of Madison County. In accordance with Alabama State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, and MEDICAL/MENTAL HEALTH TREATMENT, with the exception of psychotherapy notes. In the event the health information described below includes any of these types of information, and I initial the line below, I specifically authorize release of such information to the persons or entities indicated below.
2. I am authorizing the release of medical, alcohol or drug treatment, and mental health treatment information, the recipient is prohibited from redisclosing such information to any individual outside the Mental Health Court Program without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my medical and/or mental health related information without authorization.
3. I have the right to revoke this authorization at any time by writing to the health care provider and agencies listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. THIS AUTHORIZATION DOES NOT AUTHORIZE RECIPIENT TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE COURT, MY ATTORNEY, PARTICIPATING GOVERNMENTAL AGENCY, AND TREATMENT PROGRAM/AGENCY SPECIFIED.

By signing here : _____ I authorize the release of my health information to my attorney, Mental Health Court personnel, treatment program personnel and governmental agency, listed here:

- Southern Health Partners (Jail Psychiatric Services)
- Madison County Office of Alternative Sentencing and Release
- Mental Health Court Judge
- Madison County District Attorney's Office Attorney assigned to Mental Health Court
- Madison County Detention/Jail Facility Administration
- Wellstone, Inc.
- _____ Initial: _____
- _____ Initial: _____
- _____ Initial: _____

Reason for release of information: **ADMISSION TO AND CONTINUED PARTICIPATION IN MENTAL HEALTH PRE-TRIAL PROGRAM AND/OR ADULT MENTAL HEALTH COURT**

Event on which this authorization will expire: **COMPLETION OF THE MENTAL HEALTH PRE-TRIAL PROGRAM AND/OR MENTAL HEALTH COURT**