St. Clair County Mental Health Court Referral Application

ELIGIBILTY CRITERIA You must be over 18 years of age, a resident of St. Clair County and meet both the legal and mental health eligibility criteria. Those that meet both the legal and mental health criteria, and may have been diagnosed with a substance use disorder, are welcome to apply.

- **Legal eligibility** is determined on a case-by-case basis by the St. Clair County Prosecutor's Office. Only ordinance or misdemeanor charges will be accepted (felony reduction by prosecutor). Your current charges and prior criminal history will be considered. If you have a past or current Criminal Sexual Conduct (CSC) charge or a violent crime that resulted in death or serious bodily harm, you are **NOT** by Michigan law eligible to participate.

- **Mental Health eligibility** is determined by a review of clinical records and a mental health screen conducted by the St. Clair County CMH. You are encouraged to provide historical or current clinical reports. Those with a mental health diagnosis that seriously impairs daily functioning are eligible for participation.

CASE INFORMATION

Name _____ Date of Referral _____

Offense Date _____ Referred by _____

Docket Number _____ Referral Contact Number _____

Criminal Charge _____

Next Court Date _____

GUARDIAN _____

DEMOGRAPHIC INFORMATION

Address _____ Phone Number _____

Current Living Situation ☐ Homeless ☐ Sober Living ☐ Own Home/Apartment ☐ With Friend/Relative

Employment status: ☐ Employed full time ☐ Employed part-time ☐ Unemployed ☐ Disabled
Hours (if applicable): _____

Are you able to appear for court session set during the daytime? ☐ Yes ☐ No

MENTAL HEALTH

Have you ever been formally diagnosed with a mental health issue by a physician, psychiatrist, psychologist or therapist? ☐ Yes ☐ No.

If yes, please describe _____

Have you ever attended counseling, therapy or have been hospitalized for a mental health issue? ☐ Yes ☐ No

If yes, please describe where and when _____

Are you currently taking any medications for mental health issues? ☐ Yes ☐ No

If yes, please list the medications: _____

SUBSTANCE USE

Do you use any illegal drugs or alcohol? ☐ Yes ☐ No

If yes, list type/amount/frequency _____

Have you ever participated in a substance abuse treatment program? ☐ Yes ☐ No

If yes, when and where: _____

Are you currently in SUD treatment? ☐ Yes ☐ No

If yes, where _____

Are you in Medication Assisted Treatment? ☐ Yes ☐ No

If yes, list type, dosage, and prescribing doctor _____

DEVELOPMENTAL DISABILITY

Did you receive special education services, have an IEP, or receive a certificate of completion rather than a diploma? ☐ Yes ☐ No

If received special education services: what for, what type of services and from what grade to what grade? _____

Has a professional ever diagnosed you with a developmental disability, such as Autism, Intellectual Disability, Epilepsy, or Cerebral Palsy? ☐ Yes ☐ No

If yes, What agency and what type of professional (Psychologist, Psychiatrist, family doctor, etc...)?

_____

Do you need help with managing money, transportation, shopping, or taking medications?
☐ Yes ☐ No

If yes, what does that help look like? _____

Do you have difficulty understanding conversation, expressing thoughts, or picking up on social cues?
☐ Yes ☐ No

If yes, why is it difficult? _____

Were there delays in walking, talking, or self-care skills compared to peers?
☐ Yes ☐ No

Have you ever received, or are currently receiving, services like SSI, SSDI, or regional center support?
☐ Yes ☐ No

Do you have difficulty with planning, remembering, or making decisions about your safety or daily routine?
☐ Yes ☐ No

☐ MEDICAID ☐ NON-MEDICAID

CMH ACCESS LINE
(810) 488-8888 or walk-in visit at 3111 Electric Avenue, Port Huron

☐ CMH Screening Complete

☐ CMH Intake Scheduled for: _____

ACKNOWLEDGEMENT:

This application will be considered for the 72nd District-Adult Mental Health Court. If the defendant is not eligible for the Adult Mental Health Court the case file will remain in District and proceed as previously scheduled.

I understand that this information is intended to be used for eligibility into the 72nd District-Adult Mental Health Court. It does not guarantee my acceptance into the program. Furthermore, I understand that the demographic information contained on this form will be used for statistical reporting purposes only and will not affect my eligibility.

_____ _____
Defendant's Signature Referred by Signature

_____
Date of Application

72nd District- Adult Mental Health Court Consent for Application Processing and Eligibility

I, _____ authorize the 72nd District-Adult Mental Health Court to discuss and exchange information from this application, my eligibility assessment, and court case file. This includes information regarding my diagnosis, bond compliance, probation compliance, and substance abuse or mental health treatment. I understand this exchange of information will be among the specialty court program coordinators, program team members, and appropriate staff to process my request for treatment court participation and assess my eligibility into the program.

_____ _____

Defendant's Signature Date

RETURN COMPLETED FORM TO THE MENTAL HEALTH COURT CLERK

In person: 2nd Floor, County Building Room 2800

Fax: (810) 985-2187

Email: rshafran@stclaircounty.org

PLEASE NOTE: Incomplete applications will not be processed.