



St. Paul Txin Kaangux Healing to Wellness Court Program Referral Form

Return to: Tribal Court Administrator
court@aleut.com
Anchorage Support Office
4720 Business Park Blvd
Ste G-40
Anchorage, AK 99503

REFERRAL SOURCE

Date: _____
Referred By: _____
Phone Number: _____
Address: _____
Email: _____

Please indicate your title

Behavioral Health Clinician
DCSP Staff
Judge
Self
Other _____

APPLICANT INFORMATION

Name: _____ Home Phone: _____
Address: _____ Charges: _____
Driver's License: _____ Court Case #: _____

Has the applicant participated in a drug court before? Yes No
Does the applicant acknowledge and consent with referral? Yes No

If not, why? _____

The following criteria is used to establish applicant eligibility to participate in the TKC Program

Eligibility Requirements- Must answer YES to all

- Aged 18 or older
- Enrolled member of the Aleut Community of St. Paul Island, eligible for enrollment or subject to the jurisdiction of the St. Paul Island Tribal Court
- Resident of St. Paul Island
- Involved in repeated alcohol and/or drug related incidents and/or offenses
- Willing to participate in a structured program and submit to alcohol breath tests

Referral Signature: _____

Reminder: Make sure your referral is complete- include the following:

1. Completed TK Court Application form (Attached)
2. Signed Release of Information (ROI) forms (Both attached)
3. Court orders, if applicable
4. Criminal history records, if applicable
5. Prior assessments, if applicable

Txin Kaangux Healing to Wellness Court

REFERRAL CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION:

CIVIL JUSTICE SYSTEM REFERRAL I, _____, case number/s _____, consent to the disclosure of the following personal information:

- Criminal History
- Police Reports
- Pre-Sentence Investigation Reports
- Probation Notes
- Drug Court Case Notes
- Personal Financial Information
- Clinical Assessment Reports
- Substance Abuse History
- Treatment Recommendations/Plan
- Treatment Discharge Summary
- Residential Treatment Reports
- Psychiatric History/Testing Reports
- Emergency Room Reports
- Medical/Dental Records
- Operation/Surgery Reports
- Prescription Medications

To the following persons/organizations involved with the Aleut Community of St. Paul Tribal Government and Healing to Wellness Court:

- Judge (Tribal)
- Tribal Court Administrator
- Other TKC Staff
- Substance Abuse Treatment Providers
- Department of Community Safety and Peace
- Department of Healing and Wellness

The purpose of this disclosure is to: (1) permit the above-named persons/organizations to exchange the information listed above as it relates to my case, and (2) inform me that my TKC review hearings will be recorded on the court's register of actions, and that my participant agreement to enter the TKC and all official court orders issued during review hearings will be stored in my court file.

I understand that this consent will remain in effect and cannot be revoked by me until there has been a formal and effective termination of my involvement with the Court for this case, which may include successful completion of the program, administrative discharge, or court-ordered removal from the program.

I understand that my records are protected under the federal regulations governing confidentiality of alcohol and drug abuse patient records, 42 C.F.R. Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that my disclosure is bound by 42 C.F.R. Part 2, which governs the confidentiality of substance abuse patient records, and that recipients of this information may re-disclose it only in connection with their official duties.

(Participant Signature)

(Date)

MULTIPLE CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Txin Kaangux Healing to Wellness Court
Aleut Community of St. Paul Island Tribal Court

I, _____, authorize the Txin Kaangux Healing to Wellness Court Team to exchange information with the other initialed providers on the list below.

(Initial each agency or individual you are authorizing to exchange information; NOTE: 1-7 must be initialed)

- | | |
|---|--|
| _____ 1. Alaska Court System | _____ 5. St. Paul Tribal Court |
| _____ 2. DOC Probation Officer | _____ 6. ACSPI Behavioral Health |
| _____ 3. Public Defender Agency | _____ 7. ACSPI Department of
Community Safety & Peace |
| _____ 4. Alaska Department of Corrections | |

(Initial 8-10 if applicable)

8. Private Attorney (Initial and specify): _____
9. ASAP (Initial and specify): _____
10. Other Agency (Initial and specify): _____

The following information can be disclosed (this information may be shared verbally, electronically or in written form):

- My name and other basic demographic information
- Name of agency where I receive substance abuse treatment, my status in treatment to include attendance, compliance, treatment recommendations or changes to my discharge plan
- Results of any assessments completed by ACSPI treatment staff
- Results of ASAM and other assessments completed by the chosen or assigned Treatment Provider
- My status regarding program requirements of the Healing to Wellness Court (attendance, progress, barriers)
- My status as a patient in mental health services
- My status as a patient in on-going medical services
- Traffic and criminal record to include APSIN, NCIC, Criminal Complaints, Police Reports, PSR
- Results of Alcohol Testing

The specific purpose and need for the disclosure are to provide information to facilitate and monitor my participation in the TK Healing to Wellness Court.

I understand that this consent will remain in effect and cannot be revoked by me until there has been a formal and effective termination of my involvement with the Court for the above referenced case, which may include the following: successful completion of the program, administrative discharge, or court-ordered removal from the program.

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") 45 C.F.R. Pts. 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. Further, Federal rules prohibit agencies from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I have been provided a copy of this form.

(Signature of participant)

(Date)

TXIN KAANGUX HEALING TO WELLNESS COURT APPLICATION

CONFIDENTIAL

APPLICANT

Name of Applicant: _____Maiden Name(s)_____

Date of Birth: _____ Gender: Male Female Other

Tribal Member #: _____APSIN # (if applicable): _____ SS#: _____

of Years in Alaska: _____ E-mail Address: _____

Physical Address: _____

Mailing Address: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Ethnicity: *Check all that apply*

Ethnicity: *Check one*

American Indian

Asian

Black/African American

Caucasian

Native Hawaiian

Pacific Islander

Aleut

Athabascan

Haida

Inupiat

Tlingit

Tsimshian

Yupik

Other Alaska Native

Other: _____

Unknown

Not Spanish/Hispanic/Latino

Hispanic/Spanish/Latino

Cuban

Chicano

Mexican American

Puerto Rican

Unknown

Other: _____

Special Needs: *Select all that apply*

Developmentally Disabled	Major difficulty in ambulation
Moderate to severe medical problems	Severe hearing loss or a deafness
Traumatic Brain Injury	Visual impairment or blind
Other: _____	None

English Fluency: Excellent Good Moderate Poor Not at all

Do you feel you have a problem with reading, writing, or hearing? Yes No

If yes, please explain:

Military history: Never in Military Active Duty National Guard Reserves

Branch served: _____

Discharge type: _____

Did you ever deploy?: Yes No *If yes:* Combat Non-Combat

Are you currently involved in the military? Yes No

If yes, in which component: Active-Duty National Guard Reserves

ATTORNEY/CRIMINAL HISTORY

Attorney Name: _____ Office Phone #: _____

Are you currently in DOC Custody? No Yes, Location: _____

Do you have any of the following requirements: ASAP, Probation or Parole Yes No

If yes, please specify: _____

Name of Probation and/or Parole Officer: _____

***Do you have 2 or more prior Adult Criminal Convictions? Yes No**

***Were you Arrested UNDER the age of 16? Yes No**

***How do you feel about the crime(s) you have committed:**

Current Bail Conditions (*Select one*):

Electronic Monitoring 24/7 3rd Party Custodian Not Applicable

Other: _____

FINANCIAL

Do you have enough money to meet your basic needs: Yes No

What is your current total monthly income: _____

List sources of income: *Select all that apply*

PFDs	Trust funds	Native Corp.	VA Benefits
Employment	Village dividends	Family/Friends	Other

Do you or your household members receive any form of assistance: *Select all that apply*

Disability	Insurance	Medicaid	Social Security Insurance (SSDI)
Unemployment	Public Assistance	No Assistance	Social Security Disability Insurance (SSDI)

Are your wages being garnished for any reason? Yes No

If yes, list reason: _____

Do you have a: *Select what you have, or "no" if none apply to you*

Checking account	Savings account	Credit Card(s) # of cards: _____
Name of bank or institution: _____		No

HOUSING

Current living situation: *Select those that apply*

Private residence	Homeless/Couch surfing	Transitional living
Supported Housing: _____	Other Location: _____	

Is your housing temporary? Yes No

Are you in jeopardy of becoming homeless? Yes No

Do you live with minors? Yes No

Name/relationship of people living at the same street address as you:

_____/_____

_____/_____

_____/_____

_____/_____

_____/_____

CHILDREN'S CASES

Do you have children? If yes, how many? _____ Yes No

Name(s) & age(s): _____

Do you currently have an open file with the Office of Children's Services (OCS)?
Yes No

If so, are you in compliance with the OCS plan? Yes No

Name of OCS worker: _____

FAMILY/ SUPPORTS

Relationships	Supportive	Non-Supportive	Drug(s) or Alcohol Used	Criminal History
Mother				
Father				
Siblings				
Extended family				
Spouse or Partner				
Friends				
Acquaintances				

EMPLOYMENT/ EDUCATION

Employed Unemployed Apprenticeship

Other: _____

Current Employer/Hire Date: _____

Education:

I completed High School through grades: *Select one* 9th 10th 11th 12th

I have: *Select all that apply*

High School diploma GED Bachelor's degree
 Some graduate work (no degree) Voc. Training in: _____
 Master's degree Doctorate degree
 Post-Secondary (circle): 1 yr 2 yrs 3 yrs 4+ yrs (no degree)

SUBSTANCE ABUSE

Are you currently attending substance abuse treatment? No Yes/Agency: _____

Have you attended in the past? Yes No

Outpatient/# times: _____ Residential/#of times: _____

Do you have a problem with alcohol/drugs: Yes No

Please explain how it is a problem: _____

Primary Presenting Problem: Alcohol & Drugs Alcohol only Drugs only

Secondary: Alcohol Drugs

Substance preference: _____

Substances that you have used (Check all that apply)	More than 6 months ago	In last 6 months	Has use of any of these substances caused you problems at home, school, or work?
Nicotine (cigarettes; chew; inhalers)			
Alcohol			
Marijuana (edibles or smoking)			
Heroin			
Methamphetamines			
Amphetamines (Ritalin, Adderall)			

Pain pills/ Narcotics (opiates)			
Sedatives (Ativan, Valium, Klonopin)			
Sleeping pills (Lunesta, Ambian)			
Spice, K2			
Other synthetic street drugs			
Ecstasy			
Acid, other hallucinogens			
Weight Gain/Loss or Supplements?			
Have you ever used needles to inject drugs? Yes No			

HEALTH/MEDICAL/PSYCHIATRIC SERVICES

Are you currently (in the past six months) receiving services from any of the following:
(Select all that apply)

Medical Therapist/Psychiatrist Case Manager Other: _____

Name of Agency/Provider(s): _____

- | | | |
|---|-----|----|
| Are you currently taking medications for medical issues? | Yes | No |
| Are you currently taking medications for pain? | Yes | No |
| Are you currently taking medications for other issues? | Yes | No |
| Do you have medical, health or behavioral needs not being met at this time? | Yes | No |
| Have you ever been referred to or assessed for Anger Management Services? | Yes | No |
| Do you currently use tobacco products? | Yes | No |
| Are you interested in quitting tobacco products? | Yes | No |
| Are you interested in using medication to assist with addiction? | Yes | No |

Are you experiencing any of the following: *Select all that apply*

- | | |
|-------------------------------------|---------------------------------------|
| Negative attitude or depression | Lack of impulse |
| Lack of concern for others feelings | Hearing or seeing things other do not |
| Suicidal or homicidal thoughts | Anger or hostility |
| Other: _____ | |

The TK Healing to Wellness Court is a minimum of 15 months in length. While attending the program you will be expected to participate in the following weekly activities, court hearings, case management meetings, substance misuse counseling, breathalyzer testing and community supervision. This is a rigorous program. It is intended to address all areas of your life and help you attain your own personal goals as well as the goals of being abstinent from drugs and alcohol and ceasing involvement with the criminal justice system.

What is your current knowledge of Unangan culture and values?

PERSONAL STATEMENT

Why do you wish to be part of the Healing to Wellness Court program?

What information should the Healing to Wellness Court team consider in deciding if you should be admitted:

Applicant Name (Print): _____

Applicant Signature: _____

Date: _____