Anchorage Txin Kaanguxˆ Healing to Wellness Court Program Referral Form

Return to: Tribal Court Administrator
Attn: Tori VanderBrandt, tvanderbrandt@aleut.com
Anchorage Support Office
4720 Business Park Blvd
Ste G-42
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 Anchorage or Mat-Su, Alaska
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
Have safe, sober, and stable housing, or be willing to work with the TKC Team to identify housing, before final acceptance.

Eligibility Disqualifiers- Must answer NO to all

Charged with a crime under AS 11.41
Using medical marijuana and unwilling to discontinue use
Have a current, pending or prior Felony C cruelty to animals
A violent offender and/or has a history of drug distribution
Has committed acts of violence against law enforcement
Has a prior felony conviction within 5 yrs- exceptions apply
Used or possessed a weapon in the commission of a crime
Has intentionally caused bodily harm in the act of a crime
Has pending charges in another jurisdiction

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. Signed Consent for Criminal History Background Screening (Attached)
4. Court orders, if applicable
5. Criminal history records, if applicable
6. Prior assessments, if applicable

Txin Kaangux̂ 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 State of Alaska Court and Healing to Wellness Court:

- Judge (Tribal)
- Tribal Court Administrator
- Substance Abuse Treatment Providers
- Other TK staff

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 Kaangux̂ 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

_____2. Department of Law

_____3. Public Defender Agency

_____4. Alaska Department of Corrections

_____ 5. St. Paul Tribal Court

_____ 6. DOC Probation Officer

_____ 7. ACSPI Behavioral Health

(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)

ALEUT COMMUNITY OF ST. PAUL ISLAND

TXIN KAANGUX̂ HEALING TO WELLNESS COURT

AUTHORIZATION AND CONSENT FOR CRIMINAL HISTORY BACKGROUND SCREENING

Purpose. This form authorizes a criminal history background screening for the limited purpose of determining eligibility and suitability for participation in the Txin Kaangux̂ Healing to Wellness Court ("TK Program"). It is not an employment authorization.

Applicant Information

Full Legal Name: ____

Other Names Used / Aliases / Maiden Name: ____

Date of Birth: _________________________	**Social Security #::** ____________________
Driver's License / State (if applicable): ______________	**Phone Number:** ___________________________

Current Address: ____

Authorization

I voluntarily authorize the Aleut Community of St. Paul Island Tribal Court, the Txin Kaangux̂ Healing to Wellness Court, and their employees, agents, contractors, and designees to obtain, review, and verify criminal history and other lawfully available background information about me for the limited purpose of evaluating my eligibility and suitability for the TK Program.

I further authorize courts, law enforcement agencies, correctional institutions, probation or parole agencies, criminal justice information systems, and other entities maintaining relevant records to release such information to the Tribal Court or its authorized representatives, to the extent permitted by applicable law.

Records that may be reviewed include, as permitted by law:

- criminal history record information, including pending charges, prior convictions, and warrants;
- publicly available court records and protection order records;
- sex offender registry information;
- probation, parole, or corrections status information; and
- other lawfully obtainable records reasonably related to program eligibility, participant safety, or community safety.

Acknowledgments

☐ I understand that this authorization is for program screening and related eligibility decisions only, and that signing this form does not guarantee admission into the TK Program.

☐ I understand that refusal to sign this form may affect whether I can be considered for voluntary participation in the TK Program.
☐ I understand that information obtained under this authorization may be shared only with the Court, program staff, treatment team members, and others with a legitimate need to know for admissions, supervision, or participant-safety purposes, consistent with applicable law and program requirements.
☐ Unless earlier revoked where revocation is legally permitted, this authorization remains effective during the admissions process and, if I am admitted, during my participation in the TK Program to the extent background checks are reasonably necessary for participant or community safety and lawful program administration.

Certification

I certify that the identifying information I have provided is true and correct to the best of my knowledge. I sign this authorization knowingly and voluntarily.

______________________________	______________
Applicant Signature	*Date*
______________________________	______________
Printed Name	*Witness / Staff Signature (optional)*
	______________
	Printed Name / Title (optional)

For Court Use Only

Date Received: ______________________	**Reviewed By:** ______________________
Admission / Eligibility Decision: ______________________	**Notes:** ______________________

TXIN KAANGUX̂ 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*

- ☐ American Indian
- ☐ Asian
- ☐ Black/African American
- ☐ Caucasian
- ☐ Native Hawaiian
- ☐ Pacific Islander
- ☐ Aleut
- ☐ Athabascan
- ☐ Haida
- ☐ Inupiat
- ☐ Tlingit
- ☐ Tsimshian
- ☐ Yupik
- ☐ Other Alaska Native
- ☐ Other: ____________
- ☐ Unknown

Ethnicity: *Check one*

- ☐ Not Spanish/Hispanic/Latino
- ☐ Hispanic/Spanish/Latino
- ☐ Cuban
- ☐ Chicano
- ☐ Mexican American
- ☐ Puerto Rican
- ☐ Unknown
- ☐ Other: ____________

Special Needs: *Select all that apply*

☐ Developmentally Disabled
☐ Moderate to severe medical problems
☐ Traumatic Brain Injury
☐ Other: ____________
☐ Major difficulty in ambulation
☐ Severe hearing loss or a deafness
☐ Visual impairment or blind
☐ 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 an of the following: *Select all that apply*

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

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: ____________