LUMMI TRIBAL COURT

HEALING TO WELLNESS RECOVERY CIRCLE

2665 KWINA ROAD, BELLINGHAM, WA 98226

(360) 312-2239 / (360) 380-6994 (FAX)

Recovery Circle Applicant:

The Lummi Tribal Court has a program called the Healing to Wellness Recovery Circle (formerly known as Drug Court). This program is designed to assist a person in leading a healthy life free of drug and alcohol dependence. The HTWRC team will help and support its participants in reaching this goal.

Your Attorney and the Tribal Prosecutor have determined that, due to your recent citation for a drug or alcohol-related criminal offense, you may be a candidate for HTWRC. This is a *voluntary* program. There are several steps that must be completed before the HTWRC team can review your application and make a decision about your acceptance.

1. **Your first step is to have you defense attorney submit a completed HTWRC application to the HTWRC coordinator Bobby Lind.** Once submitted, you will need to contact the coordinator at 360-380-8666 or 360-296-0316 (business cell).
2. **Next you need to obtain a substance abuse evaluation** from Lummi Counseling Services by calling **360-312-2420,** or by another Court approved SUD Treatment agency. Be sure to let the counselor know that you will need to complete an evaluation for the purpose of participation in HTW Drug Court.
3. **Complete a risk and needs assessment by calling the HTWRC coordinator, Bobby Lind.**
4. **Next, attend an appointment for a mental health screening** with Behavioral Health by calling **360-312-2019**. Please request an evaluation/intake.
5. **Finally, come to a Recovery Court hearing and observe.** Call Bobby Lind at **360-380-8666** to find out when the next Recovery Court hearing is scheduled.

These five tasks must be completed within <u>60 days</u> of your arraignment so you must make sure you stay on top of your appointments. Your application will be forwarded for consideration to the HTWRC Team (consisting of the Judge, Probation Officer, Public Defender, Tribal Prosecutor, SUD Counselors, Mental Health Counselor and Recovery Circle Coordinator). If you have questions about the program or need assistance with the application, please contact the Coordinator at 360-380-8666. Our main goal is to see you healthy and helping the Lummi Community be a safe home for you and future generations.

LUMMI NATION Plaintiff. vs _____ Defendant.	File Stamp: **Before You File:** 1. **Defendant and Prosecutor must sign application** 2. **Give a completed copy to the Prosecutor and Coordinator.** Case No.:

HEALING TO WELLNESS RECOVERY CIRCLE

CONFIDENTIAL APPLICATION

1. PERSONAL INFORMATION

Name:		
Alias/Maiden Name:		
Date of Birth:		
Driver's License or ID No.:		State Issued:
Address:		
Lives With/Relationship:		
Emergency Contact/Relationship:		
Home Phone:	Cell Phone:	Msg. Phone:
Tribal Enrollment/Affiliation:		

2. WORK/EDUCATION INFORMATION

Are you currently employed? ☐ Yes ☐ No Are you currently enrolled in school? ☐ Yes ☐ No
Employer/School:
Hours/Schedule:

3. ATTORNEY INFORMATION

Attorney Name:	Phone:
Email Address:	

4. COURT INFORMATION

Date of Arraignment:	
Current Charge(s):	Case No.:
Current Charge(s):	Case No.:
Current Charge(s):	Case No.:
Current Charge(s):	Case No.:
Are there other criminal charges (or sentences) pending against you, including those in other Jurisdictions? ☐Yes ☐No If "yes," please explain:	
Are there any outstanding court orders pending against you? (Includes protection orders; warrants; support orders, other judgments.) ☐Yes ☐No If "yes," please explain, and name anyone that has a no-contact/protection order against you:	
Have you ever participated in a drug or DUI court before? ☐Yes ☐No If "yes," list which court, when, and if you graduated successfully:	

5. SUBSTANCE ABUSE/MENTAL HEALTH INFORMATION

Are you receiving substance abuse treatment now? ☐Yes ☐No If yes, agency:
Have you received prior substance abuse treatment? ☐Yes ☐No If yes, agency:
Are you receiving mental health treatment now? ☐Yes ☐No If yes, agency:
Have you received prior mental health treatment? ☐Yes ☐No If yes, agency:
Please list any known mental health diagnoses here:
Please list any currently prescribed medications here:

6. SIGNATURES REQUIRED

The facts set forth in the application are true and correct to the best of my knowledge, information and belief. I understand that knowingly making a false statement herein is subject to criminal penalties & exclusion from this program.

Signature of Applicant:_____ Date:_____

My attorney has reviewed this application, releases of information and policies and procedures of Drug Court, and I understand this is a voluntary program which, if accepted into the program, requires me to waive certain constitutional rights associated with trial.

Signature of Attorney for Defendant:_____ Date:_____

I understand this application for the Lummi Healing to Wellness Recovery Circle Program will not be further considered without the consent and signature of the Tribal Prosecutor.

Consent and Signature of Prosecutor:_____ Date:_____

- ❑ The prosecutor consents to the Applicant's entry into Recovery Circle.
- ❑ The prosecutor objects to the Applicant's entry into Recovery Circle for the following reason or reasons:
  - ❑ The applicant has been charged with delivery or intent to deliver illegal substances, and the applicant's entry into Recovery Circle will be against the interests of community justice.
  - ❑ The applicant has been charged with a DV related crime and the applicant's entry into Recovery Circle would be against the interests of Justice for the victim.
  - ❑ The applicant's pending charges, or previous convictions, disqualify the Applicant from applying to Recovery Circle.
  - ❑ The Applicant is facing additional charges that will disqualify them from the Recovery Circle program.
- ❑ The Applicant has been charged with delivery of an illegal substance and the prosecutor reserves consent or objection based on the outcome of the risk & needs assessment conducted by the Recovery Circle coordinator.

Please return this application to the Court Clerk at the Lummi Tribal Court and provide a copy to the Tribal Prosecutor and HTWRC Coordinator.

THINGS TO REMEMBER

The program takes approximately 13-18 months to complete but can take up to 24 months or longer if there are multiple non-compliance issues.

This is a voluntary program. The client must want to enter the program.

Defense Attorneys- The team cannot determine if someone is accepted into Recovery Circle until your client completes all the application requirements (including application form, substance abuse evaluation, appointment for mental health screening, risk and need assessment and Recovery Circle viewing).

All the Recovery Circle application requirements must be completed within 60 days of Arraignment (including application form, substance abuse evaluation, mental health screening, risk and need assessment and Recovery Circle viewing).

LUMMI HEALING TO WELLNESS RECOVERY CIRCLE

AUTHORIZATION FOR CRIMINAL BACKGROUND CHECK

As part of the Healing to Wellness Recovery Circle ("HTWRC") application process, you must consent to a criminal background investigation. The Lummi Prosecutor's Office, Lummi Clerk's Office, Lummi Nation Police Department, or other responsible agency will complete the criminal history investigation. A criminal conviction record does not *necessarily* disqualify you from the HTWRC Program. This conviction information must be disclosed before a candidate will be further considered for the HTWRC Program.

AUTHORIZATION: I,_____(PRINT NAME), authorize the HTWRC team members to obtain any criminal conviction information from any jurisdiction. I understand that this information is being used for qualification in the HTWRC Program. I hereby release you, your organization and others from any liability or damage which may result from furnishing the information requested. I understand that this authorization cannot be used to obtain any information about me that is not pertinent to my eligibility into the HTWRC Program.

A copy of this authorization shall have the same force and effect as the original. This form is valid for a period of 60 days from the date notarized. You may retain this form in your files.

Signature of Applicant: _____Date:_____

INFORMATION REQUIRED FOR CRIMINAL HISTORY BACKGROUND CHECK

INSTRUCTIONS: Complete all sections below. (Please include all names by which you are known or have ever used.) The information you provide will be used only as it relates to consideration for the HTWRC Program. PLEASE PRINT CLEARLY. If the information is not available, please indicate by placing an N/A (not available) in the space provided.

Name:_____**Alias/Maiden Name**: _____

Present Address:_____(city):_____(state):_____(zip):_____

Date of Birth: _____**Sex**: M / F **Tribal Enrollment/Affiliation**:_____(enrollment no.):_____

Eye Color: _____**Hair Color**:_____**Height**_____ **Social Security No.**: _____

****TO BE SIGNED IN FRONT OF A NOTARY****

Signature:_____Date: _____

State of Washington
County of Whatcom

I certify that I know or have satisfactory evidence that:

_____
Signed this instrument and acknowledged it to be his/her free and voluntary act for the uses and purposes mentioned in the instrument.

Signed this_____day of_____, 20_____.

_____
(Signature of Notary Public)
My appointment expires on _____

LUMMI HEALING TO WELLNESS RECOVERY CIRCLE

CONSENT FOR MUTUAL EXCHANGE OF INFORMATION

This information has been disclosed to you from records whose confidentiality is protected by the Federal Confidentiality Regulations (42 CFR, part 2) that prohibits disclosure of records without the specific written consent of the person to whom it pertains, or otherwise permitted by such regulations. A general authorization of release of medical or other information is not sufficient for this purpose.

NAME:_____ DOB:_____

I hereby authorize the mutual exchange of information (verbal and written) between the following Lummi Healing to Wellness Circle Recovery Team Members to freely discuss my Recovery Circle case:

Lummi Tribal Court	Initial	Tribal Prosecutor's Office	Initial
Public Defender's Office	Initial	Lummi Probation Office	Initial
Lummi Behavioral Health	Initial	Lummi Counseling Services	Initial
Lummi Tribal Health Clinic	Initial	Other:	
Other:		Other:	

I understand Team Members will freely discuss the facts of my case and my compliance or noncompliance in any treatment program._____(INITIAL)

I understand any information obtained by this release will be used solely for my participation in the program and will remain confidential between Recovery Circle Team Members._____(INITIAL)

I understand that this release is required for my participation in Recovery Circle._____(INITIAL)

I further understand that my drug and/or alcohol treatment records are protected under federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Insurance Portability and Accountability Act of 1996 ("HIPPA"), 45 CFR Pts. 160 & 164, and cannot be disclosed without any written consent unless otherwise provided for in the regulations. This Disclosure Authorization is specifically intended to include any diagnosis, testing, and/or treatments for communicable diseases, including sexually transmitted diseases (e.g. Tuberculosis, HIV/AIDS/AIDS related illness), mental health services, drug and/or alcohol services. I also understand that I may revoke this consent in writing at any time except to the extent that this action has been taken in reliance on it, including provisions of heath care services requiring subsequent disclosure to affect payment. Unauthorized re-disclosure by recipient is prohibited, but may be a potential risk. I understand that I do not have to sign this authorization in order to receive heath care benefits (treatment, payment, enrollment, or eligibility for benefits) except for health care services necessary to create any assessment or report for disclosure to the recipient identified in this authorization. In any event, this authorization expires automatically as follows:

This release authorization automatically expires 60 days from date of termination and/or graduation from the Healing to Wellness Recovery Circle program.

_____ _____

Client Signature Date

_____ _____

Authorized Witness Signature (e.g. Attorney, PO, Counselor, etc.) Date

LUMMI INDIAN BUSINESS COUNCIL

Lummi Behavioral Health Division
2665 Kwina Road, Bellingham, Washington 98226

Authorization of Release of Health Information (Including Alcohol/Drug Treatment and Mental Health Information) and Confidential HIV/AIDS related information I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form.

_____	Bobby Lind, coordinator, Healing to Wellness Recovery Circle
Name of Provider or Agency	Name of Person(s) to whom information will be disclosed to
_____	2665 Kwina Rd. Bellingham 98226
Address	Address
_____	360-380-6994
Fax	Fax
_____	360-380-8666
Phone	Phone

The Purpose of the Release of Information: Mutual exchange of information for coordination of services and compliance monitoring for the purposes of Healing to Wellness Recovery Circle.

_____	_____	_____
Client's Name (please print)	**Date of Birth**	Patient Identification Number

I understand that:

1. Signing this authorization is voluntary. However, I do understand I may be denied treatment in some circumstances if I do not sign this consent.
2. With some exceptions, health information, once disclosed, may be re-disclosed by the recipient. If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from disclosing such information or using the disclosed information for any other purposes without my authorization unless permitted to do so under federal law. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the Washington Division of Human Rights at 1-883-392-3644. The agency is responsible for protecting my rights.
3. I have the right to revoke this authorization verbally or in writing at any time by contacting the provider as listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization. If this authorization has not been revoked, it will terminate one year from the date of my signature unless I have specified a different expiration date. Expiration Date: 60 days after termination or graduation
4. This authorization may include disclosure of information relating to ALCOHOL and DRUG TREATMENT, MENTAL HEALTH TREATMENT and CONFIDENTIAL HIV/AIDS-RELATED INFORMATION only if I place my initials on the appropriate line in item 4.

Patient/client **check and initial** below information to be disclosed:

- ☒ CD Evaluation/Treatment Plan _____
- ☒ Mental Health Records _____
- ☐ School Records _____
- ☒ Compliance Progress Reports _____
- ☒ Discharge Summaries _____
- ☐ Health History Grid _____
- ☐ TB Skin Test Results _____
- ☒ Treatment Goals _____
- ☐ Medical Records and Physical _____
- ☒ UA Results _____
- ☐ HIV/AIDS-related information _____
- ☐ Court/Probation Records _____
- ☐ Other _____

I understand that my alcohol and/or drug treatment records are protected under federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") , 45 CFR Parts 160 & 164 and cannot be disclosed without written consent unless otherwise provided for in the regulations.

_____	_____
Signature of Patient	Date
_____	_____
Signature Authorized Representative (State relationship to patient)	Date

This form has been approved by the Lummi Department of Health and Human Services to permit release of health information. However, this form does not require health care providers to release health information. Alcohol/drug treatment-related information or confidential HIV-related information released through this form must be accompanied by the required statements regarding prohibition of re-disclosure. *Note: Information from mental health clinical records may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person.