LUMMI FAMILY WELLNESS COURT
APPLICATION

1. FAMILY INFORMATION

Your Name:		Alias/Maiden Name:	
Date of Birth:	Driver's License or ID No.:		State Issued:
Home Phone:	Cell Phone:	Msg. Phone:	
Address:			
Who lives with you:			
Spouse/Life Partner Name:		Will they be part of FWC? ☐ Yes ☐ No	
Children's Names:		Date of Birth:	Will they be part of FWC?
(1)			☐ Yes ☐ No
(2)			☐ Yes ☐ No
(3)			☐ Yes ☐ No
(4)			☐ Yes ☐ No
(5)			☐ Yes ☐ No
(6)			☐ Yes ☐ No
Emergency Contact/Relationship:			
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:
Address:	

4. COURT INFORMATION

Date Dependency Case Was Opened?	
Any Other Current Legal Issues (including criminal charges): ☐Yes ☐No	Explain:
Are you on Probation? ☐Yes ☐No	Explain:
Have you ever participated in a drug court or family 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. Eligibility Questions

Are you a descendant or an enrolled member of the Lummi Nation? ☐ Yes ☐ No
Are your children (in this dependency case) a descendant or an enrolled member of the Lummi Nation? ☐ Yes ☐ No
Do you reside within Whatcom County and agree to reside in county for duration of FWC? ☐ Yes ☐ No
Do you have a felony for violent crime within the last ten years? ☐ Yes ☐ No
Do you have a pending charge for a felony assault charge? ☐ Yes ☐ No
Do you have a pending drug delivery charge? ☐ Yes ☐ No
Have you had parental rights terminated in this dependency case? ☐ Yes ☐ No
Do you agree to engage in services (e.g. treatment, counseling, etc.) on the Lummi Reservation? ☐ Yes ☐ No
Do you agree to voluntarily participate in the FWC program? ☐ Yes ☐ No
Explanation/Comments:

7. SIGNATURES REQUIRED

The facts set forth in the application are true and correct to the best of my knowledge, information and belief.

Signature of Applicant:_____ Date:_____

My attorney has reviewed this application, releases of information and policies and procedures of Family Wellness 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 Parent Counsel:_____ Date:_____

I understand this application for the Lummi Family Wellness Court Program will not be further considered without the consent and signature of the ICW Attorney.

Consent and Signature of ICW Attorney:_____ Date:_____

Please return this application to the Court Clerk at the Lummi Tribal Court and provide a copy to the ICW Attorney.

THINGS TO REMEMBER

The program takes approximately 12 months to complete, but can take longer if there are multiple violations.

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

LUMMI FAMILY WELLNESS COURT

CONSENT FOR MUTUAL EXCHANGE OF INFORMATION

This information has been disclosed to you from records whose confidentiality is protected by the Lummi Nation Code (8.01.180) 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 Family Wellness Court Team Members to freely discuss my Drug Court case:

Lummi Tribal Court	Indian Child Welfare Office
Parent's Counsel	Lummi Tribal Health Clinic
Lummi Behavioral Health	Lummi Counseling Services
Lummi Housing Authority	Lummi Employment & Training Center
Guardian Ad Litem	Lummi Children's Services
Lummi Probation Office	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 Drug Court Team Members._____(INITIAL)

I understand that this release is required for my participation in Drug Court._____(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 18 months from date of authorization, or termination and/or graduation from the Family Wellness Court program, whichever occurs sooner.

_____ _____

Client Signature Date

_____ _____

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

LUMMI TRIBAL HEALTH CENTER
2592 Kwina Road, Bellingham, Washington 98226
360-384-0464 PHONE 360-384-2337 FAX

Authorization of Release of Health Information (Including Alcohol/Drug Treatment and Mental Health Information) and Confidential HIV/AIDS related information

I,_____ _____ _____
Name of Patient (please print) Date of Birth Patient Identification Number
or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form.

Lummi Tribal Health Center
Name of Provider or Agency

2592 Kwina Road Bellingham, WA 98226
Address:

(360)384-2337
Fax:

(360)384-0464
Phone:

Name of Person(s) to whom information will be disclosed to

2665 Kwina Road Bellingham,WA 98226
Address:

(360) 380-6994
Fax:

(360) 312-2433
Phone:

The Purpose of the Release of Information: ☐ Further Medical Care ☐ Insurance ☐ Attorney
☐ Personal ☐ School ☐ Disability

I understand that:

1. 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.

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: _____

4. Signing this authorization is voluntary. However, I do understand I may be denied treatment in some circumstances if I do not sign this consent.

Patient/client initial below information to be disclosed:

Only the period of events from: _____ to: _____

☐ Mental Health Records ☐ Discharge Summaries ☐ Health History Grid
☐ TB Skin Test Results ☐ Medical Records and Physical ☐ UA Results
☐ HIV/AIDS-related information ☐ Sexual Transmitted Diseases
☐ Other _____

All items on this form have been completed, my questions about this form have been answered and I have been provided by a copy of the form. ☐ _____Initial 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 of Authorized representative Date
(State relationship to patient)

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.

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.

Name of Provider or Agency	Family Wellness Court Coordinator Name of Person(s) to whom information will be disclosed to
2616 Kwina Rd. Bellingham 98226 Address	2665 Kwina Rd. Bellingham 98226 Address
360-384-2349 Fax	360-380-6994 Fax
360-312-2420 Phone	360-312-2433 Phone

The Purpose of the Release of Information: Coordination of services for purpose of Family Wellness Court

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: ___

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

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.