Mental Health Diversion Program

The City of Olathe Prosecutor's Office has partnered with Johnson County Mental Health Center (JCMHC) to extend their diversion program to include assistance for defendants experiencing symptoms of a serious mental illness. The purpose of this program is to direct defendants into needed care and treatment with JCMHC to improve their quality of life and to reduce recidivism.

Eligibility—Mental Health Diversion may be available to defendants who meet the following criteria:

- Experiencing symptoms of a serious mental illness
- JCMHC's criteria for a functional level of care.
- JCMHC's residency requirements.
- Willing to participate in all services as directed by JCMHC.
- Maintain a release of information between JCMHC and Olathe Prosecutor's Office throughout the diversion term.

Applying—Application packets are available in the Olathe Prosecutor's Office as well as with Olathe Municipal Court Judges. Please direct any questions and/or return completed packets to the Prosecutor's Office as final determination of eligibility will be at their discretion.

CITY OF OLATHE MENTAL HEALTH DIVERSION APPLICATION

**You must be a Johnson County resident to apply for mental health diversion and accept services through Johnson County Mental Health during the term of your diversion. **

FULL LEGAL NAME: ____
MAIDEN NAME: __________________ PREFER TO BE CALLED______________
Date of Birth: ___________ Social Security #: ___________________________
MALE___ FEMALE ___ SINGLE___ MARRIED___ DIVORCED ___ WIDOWED ___
ADDRESS: ____
(Street#, Name, Apt.#) (City, State, Zip) (County)
Who do you reside with and what is their relationship to you?

____

____

TELEPHONE: HOME/CELL: ________________ WORK: ______________
DRIVER'S LICENSE NUMBER and STATE: ____________________ CDL? _____
Are you currently employed? YES_____ NO_____
If so, where____
How long? ______________________________
What is your highest level of education? Elementary_____ Jr. High____ GED____
High School Diploma____ Some College ____College Degree____ Graduate School____
Did you have an IEP or Special Education Services YES_____ NO______
Attorney's Name: ____

LEGAL HISTORY:

DO NOT LEAVE ANYTHING BLANK; INDICATE "NONE" IF YOU HAVE NOTHING

LIST ANY PRIOR OR PENDING CRIMINAL CHARGES, ARRESTS, OR CITATIONS:
(Include anything dismissed, diverted, expunged, or juvenile)

Charge Where When Outcome/Disposition

a.____
b.____
c.____
d.____
e.____

(If you need more room, record any additional charges on back)

MEDICAL HISTORY

Do you currently receive Medicaid/Medicare Disability benefits? YES_____ NO_____
Have you ever participated in Mental Health Treatment? YES_____ NO_____
What is your diagnosis? ____
Have you ever been hospitalized for Mental Illness? YES_____ NO_____
When____________________ Where___________________________________
Have you ever participated in Substance Abuse Treatment? YES_____ NO_____
When____________________ Where___________________________________
What substance(s)? ____
What psychiatric medications have you ever been prescribed?

____

____

____

What psychiatric medications are you **currently** taking?

____

____

____

At the time of the current charge(s), were you taking any medications? YES____ NO____
Please list: ____

STATE IN YOUR OWN WORDS AND IN DETAIL THE FACTS WHICH CAUSED CHARGES TO BE FILED IN THE CURRENT CASE:

____

____

____

____

____

The information contained in this application is true and correct. All information related to prior offenses whether convicted, diverted, reduced, dismissed or expunged has been disclosed. I understand that failure to disclose requested information or making false statements shall be grounds for denial of or termination from diversion. I further understand that I must inform the prosecutor if any of the above information changes prior to signing the actual diversion contract.

____
DEFENDANT'S SIGNATURE DATE

(YOU MUST ANSWER ALL QUESTIONS, OR YOUR DIVERSION APPLICATION WILL NOT BE ACCEPTED.)

JOHNSON COUNTY KANSAS
Mental Health

6000 Lamar, Ste 130, Mission, KS 66202
PH: 913-826-4200 FX: 913-826-1534
Website: jocogov.org/mentalhealth

AUTHORIZATION TO DISCLOSE PROTECTED HEALTHCARE INFORMATION

Office Use ONLY
Immediate Action Needed: ☐ File Only ☐ Request Records ☐ Request Sent Staff Signature

Name of Client | (Maiden Name, if applicable) | Last 4 digits of SSN | DOB | JCMHC ID

I hereby authorize **Johnson County Mental Health Center**: ■ to disclose to AND/ OR ■ to receive from

Olathe Municipal Court and Olathe Prosecutor's Office
(agency, program, or individual, if an individual, identify relationship to client)

Address 1200 S Harrison St City/State Olathe, Kansas Zip Code 66061

Phone ______ Fax Number ______ Email ______

Type of records authorized to be disclosed, one or both record types must be marked to be a valid authorization ☐ Mental Health and/or ☐ Substance Abuse

JCMHC to Disclose (mark each that apply)		JCMHC to Receive (mark each that apply)	
■ Acknowledgement of Treatment		■ Acknowledgement of Treatment	
☐ Billing and/or Insurance Info		■ Billing and/or Insurance Info	
■ Diagnosis		☐ Child Welfare Placement	
■ Discharge Summary / Plan		☐ Diagnosis	
■ Intake / Admission Information		☐ Discharge Summary / Plan	
☐ KCPC (Electronic Version ONLY)		☐ Immunization	
☐ Labs		☐ Intake / Admission Information	
☐ Med/Psych Notes (date range)	__/__/__ to __/__/__	☐ KCPC (Electronic Version ONLY)	
■ Medications Prescribed		☐ Labs	
■ Other:	Monthly Diversion Reports	☐ Med/Psych Notes (date range)	__/__/__ to __/__/__
☐ Other:		☐ Medical History	
■ Plan of Care / Treatment Plan		☐ Medications Prescribed	
■ Progress Notes (date range)	__/__/__ to __/__/__	■ Other:	Diversion application/ Criminal Case History
☐ Progress Summary (letters)		☐ Plan of Care / Treatment Plan	
■ Psychiatric Eval/Reports		☐ Progress Notes (date range)	__/__/__ to __/__/__
☐ Psychological Eval/Reports		☐ Progress Summary (letters)	
☐ TB Results		☐ Psychiatric Eval/Reports	
☐ UA		☐ Psychological Eval/Reports	
		☐ School Report/IEP/504	
		☐ TB Results	
		■ UA	
		☐ Waiver Documents	

I understand this information will be used for **the following purpose(s)**:

- ■ **Coordinating Client Care/Treatment**
- ☐ **Coordinating Client Care and Billing/Reimbursement**
- ☐ **Court Testimony (Subpoena Required)**
- ☐ **Emergency Contact**
- ☐ **Records are Requested by the Client/Guardian for Personal Use**
- ■ **Other:** court testimony, written or verbal reports with regard to MH Diversion

I understand that the healthcare information may include medical, psychiatric, alcohol and drug abuse, diagnosis or treatment &/or HIV information. Unless otherwise specified, health care records within the last six months of services will be disclosed. I understand that my records are protected by law and cannot be disclosed or re-disclosed without my consent. However, records disclosed from Johnson County Mental Health Center to a non- covered entity may be subject to re-disclosure and no longer protected. I understand that I am not required to authorize the disclosure of my protected healthcare information to receive treatment. I may request a copy of this authorization and the information disclosed. I may revoke this authorization, in writing, at any time with the exception of situations in which Johnson County Mental Health Center has taken action in reliance on the authorization. A photo or electronic copy of this authorization is considered as valid as the original. By signing this authorization I acknowledge I have read and understand the disclosures I have authorized and I have the legal right and authority to sign this document. ***Unless I revoke it earlier, this consent will expire in 365 days, or other length of time indicated.***

☐ **30 Days** ☐ **60 Days** ☐ **90 Days** ☐ **180 Days**

Signature of Client (age 14 or older) | Printed Name of Client | Date Signed

Signature of Parent or Legal Guardian | Printed Name of Parent or Legal Guardian | Date Signed

Client/Guardian may revoke the ROI verbally, by written statement or using the Revocation of Release of Information form. Revocation form and full policy is on our website: jocogov.org/mentalhealth or at any of our locations.
Revocation Disclaimer Substance Abuse Services Only: **If my treatment was ordered by the court, this permission cannot be revoked until I am officially released from confinement, parole, or probation

Prohibition on Redisclosure: This information has been disclosed to you from records whose confidentiality is protected by law. 42 CFR Part 2 and other state and federal laws prohibits unauthorized disclosure of these records.

Consent to Release/Receive Information

I, ______________________________ D.O.B.__________ S.S.#________________,
hereby authorize the release of information held in my records to and/or from ***City of Olathe Court Services*** to be directed to the following individual(s) or organization(s), and only under the conditions set out below:

1. Disclosure is made to or received from:
   City of Olathe Prosecutor's Office
   City of Olathe Municipal Court
   Johnson County Mental Health Center
   Other: (Attorney) ______________________________
   Other: ______________________________

2. **Information to be disclosed:** Evaluation, information within the Prosecutor's Office/Court Services file, and/or client information pertaining to education, treatment, employment, substance use testing, and/or all medical records.

3. **The purpose of the disclosure authorized in this consent is to:** Set terms of the Mental Health Diversion and enable compliance monitoring of terms.

4. This consent form is valid for one year or completion of Mental Health Diversion, whichever may last occur.

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing confidentiality of patient records and cannot be disclosed without my written consent unless provided for in the regulations.

I also understand that this consent may be revoked by me at any time except if the action has already been taken in accordance with this consent. I further understand that revoking this consent during the term of the Mental Health Diversion may result in revocation of the Diversion Agreement.

____
Signature of Client — Date

____
Signature of Parent/Legal Guardian — Date

____
Signature of Witness — Date