Mental Health Diversion

What:
Overland Park Municipal Court (OPMC) has partnered with Johnson County Mental Health (JCMH) to create a diversion program for defendants suffering from symptoms of a Serious Mental Illness. The objective of the Mental Health Diversion is to direct the defendant into treatment with JCMH and reduce recidivism.

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

- Suffer from symptoms of a Serious Mental Illness
- Meet JCMH's criteria for functional level of care.
- Meet JCMH residency requirements
- Be willing to participate in all services as directed by JCMH
- Maintain a Release of Information between JCMH and OPMC at all times.

How to apply:
Application packets are available from the Overland Park Prosecutor as well as Municipal Court Judges. Please return completed packets to the Prosecutor's Office.

All questions should be directed to the Prosecutor's Office. Final determination of eligibility will be at the Prosecutor's discretion.

FOR OFFICE USE ONLY
Case number: _____
Charge (s): _____
Application date: _____

OVERLAND PARK, KS 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 **

NAME: _____ MAIDEN NAME: _____
DOB: _____ SSN: _____
MALE _____ FEMALE _____ SINGLE _____ MARRIED _____
ADDRESS: _____
(Street #, Name, Apt.#) (City, State, Zip)
Who do you reside with and what is their relationship to you?
_____

TELEPHONE: HOME/CELL: _____ WORK: _____

ATTORNEY: _____

DRIVER'S LICENSE NUMBER and STATE: _____

Are you currently employed? _____ YES _____ NO

If so, where_____

How long? _____

What is your highest level of education? _____High School _____Some College
_____ College _____ Graduate School

Did you have an IEP or Special Education Services _____ YES _____ NO

LEGAL HISTORY:

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

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

	Charge	Where	When	Outcome
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 this incident, were you taking any medications? _____ YES _____ NO

Please list? _____

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

_____

_____

_____

_____

_____

_____

The information contained in this application is true and correct. All information related to prior offenses whether convicted, diverted, reduced or dismissed have been disclosed. I understand that failure to disclose pertinent information or 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

Overland Park Municipal Court and Overland Park Prosecutor's Office

(agency, program, or individual, if an individual, identify relationship to client)

Address 12400 Foster City/State Overland Park, Kansas Zip Code 66213

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:		☐ Med/Psych Notes (date range)	____/____/____ to ____/____/____
☐ Other:		☐ Medical History	
☒ Plan of Care / Treatment Plan		☐ Medications Prescribed	
☒ Progress Notes (date range)	____/____/____ to _____/____	☒ Other:	
☐ 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.