Superior Court of California, County of Solano

Veterans Treatment Court/Military Diversion Referral Packet

Court Information

Date of Referral		Case Number(s)	
Attorney of Record		Attorney Phone	
☐ Public Defender ☐ Alternate Public Defender ☐ Private Attorney ☐ Other			

Client Information

Name	First*	Middle*	Last*	
Mobile Phone*			Other Phone	
Date of Birth*			Last 4 SSN*	
Address			Unhoused? ☐ Yes ☐ No	
Email				
The following information is collected for grant-reporting purposes and does not affect your eligibility or case.				
Race	Check all that apply: ☐ White ☐ Black ☐ Asian ☐ American Indian/Alaska Native ☐ Pacific Islander ☐ Other			
Hispanic/ Latinx	☐ Yes ☐ No		Sexual Orientation	☐ Straight/Heterosexual ☐Gay/Lesbian ☐ Bisexual ☐ No Answer
Sex at birth			Day to Day Gender	

Military Information

Are you enrolled in VA Healthcare?	☐ Yes ☐ No
If yes, where?	☐ Travis ☐ Mare Island ☐ Martinez ☐ Other
If no, who is your provider?	☐ Medi-Cal ☐ Kaiser ☐ Private Insurance
Service Connected Disability?	☐ Yes Percent (%) _____ ☐ No ☐ I don't know
Conditions/ Diagnoses	☐ PTSD ☐ Traumatic Brain Injury ☐ Mental Health ☐ Substance Use ☐ Military Sexual Trauma ☐ Other:

Military Status	☐ Veteran ☐ Active Duty ☐ Retired ☐ National Guard ☐ Reservist

*Required fields. Client or attorney must fill in this information for screening to occur.

Client must sign attached VA Release of Information (ROI) and **Court ROI.** Send this entire completed packet (with both ROIs) to Karen Sheehy, Senior Case Manager, at kasheehy@solano.courts.ca.gov or 707-426-4453 (Fax).

Revised 02/07/2024

Veterans Treatment Court/Military Diversion Programs

Consent to Release Information and Consent to Obtain Information

I, _____, authorize the Solano County Superior Court's Veterans Treatment Court (VTC) and Military Diversion (MD) teams to exchange (provide and receive) information pertaining to me to determine my eligibility for the program and to assess my progress in the program. I understand that the teams include staff from the following entities:

Solano County Alternate/Public Defender's Office: Pamela Boskin, Alvir Sadwani, Natalie Thompson, Frances Wood
Solano County District Attorney's Office: Jeffrey Daley, Shelly Moore
Solano County Probation Department: Natalie Estrada, Russel Stevens, Melani Zamora
Solano County Veterans Services: Joel Ceja, Alfred Sims
Superior Court of California, County of Solano: Judge Janice Williams, Judge Daniel Healy, Collaborative Courts Manager Cynthia Garcia; Case Manager Karen Sheehy
U.S. Department of Veteran Affairs Healthcare System: Kelli Nance, LCSW, Licensed Mental Health Clinician and Veterans Justice Outreach Specialist (VJO)

☐ My defense attorney: _____

Information may also be exchanged with the following Treatment Providers:

☐ Clinics and Hospitals of VA Northern California Healthcare System
☐ Veterans Center: Location_____
☐ Other: _____
☐ Other: _____

The information obtained or released pursuant to this authorization form may include, but is not limited to, assessments performed on me, my medical information, current and past treatment plans, my progress in treatment, my clinical data and diagnoses, and my VA disability status.

I understand that my records are protected by the provisions of 42 United States Code (USC) Section 290dd-2, and the regulations implementing these laws at pt. 2, subch. A, ch. 1, tit. 42 of the Code of Federal Regulations (CFR), and cannot be disclosed without my written consent unless otherwise provided in the laws or regulations. I also understand that I may revoke this consent at any time except to the extent that a person/entity with authority to do so has already acted in reliance on it, and that in any event this consent will expire on the date that the VTC team determines my ineligibility for the program, or

Thirty (30) days after termination/graduation from VTC or ☐ _____

Date:_____ _____
Participant (print name)

_____
Signature of Participant

Date: _____ _____
Signature of Case Manager

THIS FORM MUST BE FAXED OR EMAILED TO:
Karen Sheehy, VTC Case Manager FAX NUMBER: (707) 426-4453
EMAIL: vtc@solano.courts.ca.gov
Failure to fax or email this form may cause a delay in the screening/assessment process

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

PRIVACY ACT AND PAPER WORK REDUCTION ACT INFORMATION: The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Act. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless is displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 2 minutes. This includes the time it will take to read the instructions, gather the necessary facts and fill out this form. The execution of this form does not authorize the release of information other than that specifically described below.

The information requested on this form is solicited under Title 38 U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164; 5 U.S.C. 552a; and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if information needed to locate records for release is not furnished completely and accurately, VA will be unable to comply with the request. The Veterans Health Administration may not condition the provision of treatment, payment, enrollment in the VA Health Care Program, or eligibility for benefits on the signing of an authorization, except for research-related treatment where an authorization for the use or disclosure of individually-identifiable health information for such research is required. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act system of records notices identified as 24VA10A7 "Patient Medical Record - VA", 08VA05 "Employee Medical File System Records (Title 38)-VA" and in accordance with the Notice of Privacy Practices. VA may also use this information to identify Veterans and person claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

TO: DEPARTMENT OF VETERANS AFFAIRS *(Name and Address of VA Health Care Facility)*

VA Northern California Healthcare System (VANCHCS)
10535 Hospital Way, Mather, CA. 95655.
Or any other VHA Hospital or VA CBOC where the veteran will receive services.

LAST NAME- FIRST NAME- MIDDLE NAME	DATE OF BIRTH *(mm/dd/yyyy)*

PATIENT'S MAILING ADDRESS (*including City, State and Zip Code*)

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL, OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

Veteran Treatment Court VTC / Military Diversion MDP programs of Solano County.
Solano County Superior Court; District Attorney, Public Defender, Probation Department
PO,County Veteran Service Officer CVSO, CCC Court Mentor. Other; _____
List Private Attorney here_____

PURPOSE(S) OR NEED: Information is to be used by the requestor for:

☒ TREATMENT ☒ BENEFITS ☒ LEGAL ☒ EMPLOYMENT ☒ OTHER *(Please specify)* Community Partners

INFORMATION REQUESTED: Check applicable box(es) and state the extent or nature of information to be provided:

☐ HEALTH SUMMARY *(Prior 2 Years)*

☐ INPATIENT DISCHARGE SUMMARY *(Dates)*: _____

☐ PROGRESS NOTES:

- ☐ SPECIFIC CLINICS *(Name & Date Range)*: _____
- ☐ SPECIFIC PROVIDERS *(Name & Date Range)*: _____
- ☐ DATE RANGE: _____

☐ OPERATIVE/CLINICAL PROCEDURES *(Name & Date)*: _____

☐ LAB RESULTS:

- ☐ SPECIFIC TESTS *(Name & Date)*: _____
- ☐ DATE RANGE: _____

☐ RADIOLOGY REPORTS *(Name & Date)*: _____

☒ LIST OF ACTIVE MEDICATIONS: Ongoing VA medication list if court ordered

☐ FLU VACCINATION *(Dose, Lot Number, Date & Location)*: _____

_____

☒ OTHER *(Describe)*: Verbal communications with organizations/individuals listed above.

LAST NAME- FIRST NAME- MIDDLE NAME	DATE OF BIRTH *(mm/dd/yyyy)*

SENSITIVE DIAGNOSES: REVIEW AND, IF APPROPRIATE, COMPLETE WHEN RELEASE IS FOR ANY PURPOSE OTHER THAN TREATMENT.

I request and authorize Department of Veterans Affairs to release the information pertaining to the condition(s) below for the non-treatment purpose(s) listed in this authorization.

☒ DRUG ABUSE ☒ ALCOHOLISM OR ALCOHOL ABUSE ☐ SICKLE CELL ANEMIA

☐ HUMAN IMMUNODEFICIENCY VIRUS *(HIV)*

I understand that information on these sensitive diagnoses may be released for treatment purposes without me checking the above boxes, and will be released even if the boxes are unchecked unless I indicate by checking the box below that I do not want this information released for this specific disclosure.

☐ **I do not want sensitive diagnoses released for treatment purposes under this specific authorization. I realize this does not impact other future requests unrelated to this authorization.**

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing records. Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

I understand that the VA health care provider's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions.

EXPIRATION: Without my express revocation, the authorization will automatically expire *(select one of the following)*:

☐ AFTER ONE-TIME DISCLOSURE, IF ALL NEEDS ARE SATISFIED

☐ ON *(mm/dd/yyyy)* _____ *(enter a future date other than date signed by patient)*

☐ UNDER THE FOLLOWING CONDITION(S): Three years following the date of signature

PATIENT SIGNATURE *(Sign in ink)*	DATE *(mm/dd/yyyy)*

LEGAL REPRESENTATIVE SIGNATURE (*if applicable) (Sign in ink*)	DATE *(mm/dd/yyyy)*

PRINT NAME OF LEGAL REPRESENTATIVE	RELATIONSHIP TO PATIENT

FOR VA USE ONLY

TYPE AND EXTENT OF MATERIAL RELEASED

Verbal and/or written information related to eligibility status; health problems and medical care; MH treatment; medication compliance; substance abuse treatment; UA and PBT results. Information will be shared at regular intervals as needed by the court team to adequately assess progress of veterans compliance with court and probation guidelines. Information will include but not limited to: Diagnosis (medical, mental health, and substance abuse/alcohol), relevant labs, medical diagnosis, progress in treatment programming, developmental, social, financial and military data as relevant to court/legal circumstances to the designated court team and additional guests as permitted by authorization. Purpose/Need; information is to be used by the individual for community partners, housing, outpatient programs, Vet Center, County Veterans Services Office CCC. This authorization will expire upon veterans discharge or successful completion of the court program and probation which may last longer than the court program.

DATE RELEASED *(mm/dd/yyyy)*	RELEASED BY: