SOUTHWEST IOWA MENTAL HEALTH COURT APPLICATION

IN THE IOWA DISTRICT COURT IN AND FOR _____ COUNTY

STATE OF IOWA,)
Plaintiff,) Case No.:_____

VS.) ***MENTAL HEALTH PLEA AGREEMENT***

Defendant.)

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1. The Defendant enters a plea of guilty to the offense(s) of

   _____

   _____

2. The range of sentences possible under this plea in accordance with the above statutes consists of:

   _____

   _____

   _____

   _____

3. The following charges are dismissed in consideration of this plea:

   _____

   _____

   _____

   _____

4. A sentencing date will be set by the Court, pending the Defendant's enrollment and completion of Mental Health Court. By this agreement, the Defendant agrees

to enroll and complete Mental Health Court as specified further herein. Defendant agrees that should he/she fail to complete Mental Health Court, he/she may be sentenced immediately by the Mental Health Court Judge on the charges pled to herein. The conditions of the Mental Health Court will have the following marked special conditions:

Please Review with Applicant:

_____ (A) The Defendant agrees to enter into the Fourth Judicial District Mental Health Court for a period of (12) months or (24) months and successfully complete the Program. This time period may be extended or lessened by the Mental Health Court Judge.

_____ (B) Report to the Probation Officer in charge of Mental Health Court at once.

_____ (C) Pay the sum of **$300** to the Fourth Judicial District, Department of Correctional Services **(as a supervision fee).**

_____ (D) Undergo a mental health evaluation by the therapist and successfully comply with and complete all recommendations of Court for treatment. If other evaluations are needed for eligibility or for a treatment plan, the defendant will cooperate with those evaluations and also comply with any treatment that is recommended. Undergo substance abuse/addiction evaluation and successfully complete all treatment as determined necessary which could include the Gains Screener, PHQ9 Screener, Co-Occurring Disorder Screener, and the SASSI-4.
*If Applicable, will provide testing for cognitive functioning if ID or TBI or agrees to complete new testing with the therapist.

_____ (E) Enroll in GED/Vo-Tech Program/college and successfully complete the same as determined appropriate. Maintain steady employment during participation in the Mental Health Court Program.

_____ (F) Make restitution to the victim according to a schedule to be worked out by the Probation Officer and approved by the Court

_____ (G) Remain drug and alcohol free; stay out of bars and away from illicit drugs and substance abusers/users.

_____ (H) Take prescription medication ONLY with the permission of the Treatment Provider, and provide all prescriptions to the therapist and case manager.

_____ (I) The defendant will sign the SWIMHC Release of Information form which is attached.

_____(J) The defendant will complete the SWIA MHDS Regional Application, which is available on request if Regional Funding is required.

5. The Defendant agrees to all Mental Health Court rules and regulations and promises to abide by and obey the orders of the Mental Health Court Judge, and understands that multiple positive drug tests, which indicate the presence of a uniform controlled dangerous substance under Iowa law, or the attempt to falsify a drug test may result in expulsion from the program and the imposition of sentence.
6. The Defendant understands that the application and admission process may require him/her to waive due process rights which he/she may have under the Constitution of the United States and the Constitution of the State of Iowa involved in the administration of Mental Health Court, and in particular the imposition of sanctions by the Mental Health Court Judge, including, but not limited to, the waiver of the ninety (90) day and one (1) year speedy trial requirements by Iowa Rules of Court. These rights will be explained by his/her counsel when a waiver is required.
7. The Defendant agrees to all sanctions imposed by the Mental Health Court Judge, including jail service, community service, frequent court visits and appearances, increased drug testing, AA and NA meetings, individual and group counseling sessions, and any conditions of probation which, in the judgment of the Court, are necessary or beneficial to the Defendant.
8. The Defendant agrees to attend and report to Mental Health Court, his/her Probation Officer and the Treatment Provider as ordered by the Mental Health Court Judge.
9. The Defendant specifically agrees to pay whatever amount his/her Probation Officer/Case Manager recommends and the Mental Health Court approves, to help defray the costs of his/her treatment and participation in the Mental Health

Court Program. This is based on both the defendant's ability to pay as well as cooperation in any application process which allows access to benefits or payment for providers.

10. The Defendant expressly waives his/her right to recuse the Mental Health Court Judge, should he/she fail to complete the program, be revoked and sentenced in accordance with this plea agreement.

11. The Defendant understands and expressly waives his/her right to contest his/her extradition under the laws of the State of Iowa, federal law, or any State where he/she may be found should he/she leave the State of Iowa and become subject to extradition back to the State of Iowa.

12. The Defendant and his or her counsel assert that they have disclosed all criminal history and pending charges, whether in the Fourth Judicial District, or elsewhere as indicated below:

_____

_____

_____

_____

13. Does the Defendant have minor children? Yes or No.
In the space below list minor children's' names and ages and whether they reside with Defendant or have another placement (other parent/family member/foster care/etc)

_____

_____

_____

**Does the Defendant currently have a child protection case with DHS-or any involvement with DHS to include the following: (juvenile court case; safety services with DHS; voluntary services with DHS; or otherwise involved with DHS for: abuse assessment; family assessment; or CINA assessment)?
LIST BELOW

_____

_____

_____

_____

14. The Defendant understands the nature of this plea agreement and the full effect of the agreement, and specifically declares that this agreement contains all of the conditions and agreements of the Defendant, the Court and the State of Iowa.

15. The Defendant understands, waives and gives up the following constitutional rights and enters a plea herein:

    (a) The right to plead not guilty.

    (b) The right to trial by a jury or a judge.

    (c) The right to be represented or helped by counsel (a lawyer) of his/her choice, or if he/she cannot afford counsel, his/her right to be represented by court-appointed free counsel.

    (d) The right to compel or make witnesses come to trial to testify in his/her behalf.

    (e) The right to cross examine witnesses that testify against him/her.

    (f) The right to be present when witnesses testify against him/her.

    (g) The right to remain silent and not testify.

    (h) The right to appeal all matters relating to the trial and sentencing, including the issue of guilt or innocence.

    (i) The right to motion in arrest of judgment.

16. The Defendant acknowledges and states that the above-listed rights have been carefully explained to him/her by the Judge in Court, and by his/her attorney, and that he/she fully understands what he/she is doing by pleading guilty to this offense(s). The Defendant further acknowledges that he/she has read the above rights and fully understands his/her above-listed rights and wishes to waive all of them.

17. The Defendant understands the elements of the crime he/she is charged with and entering a plea to, and the maximum and minimum periods of incarceration and

fines, as well as any mandatory minimums that apply, with regard to the charges as are indicated on page one (1) of this agreement.

18. The Defendant has reviewed the facts of this case with his/her attorney, and agrees that there are sufficient facts available to the State to justify the plea of guilty that he/she enters to the charges. The Defendant has further reviewed the Trial Information filed by the State in this case, and the Defendant acknowledges and stipulates that if called to testify, these witnesses would testify in accordance with the minutes of testimony, and there is a factual basis for the charge(s).

19. The Defendant expressly declares he/she has not had any drug, alcohol, or medication of any kind in the past twenty-four (24) hours except:_____

_____

And will be asked to assert during the plea proceedings that he/she has not ingested anything that will impair his/her ability to understand the proceedings.

20. The Defendant declares that he/she has entered into this plea agreement freely and voluntarily of his own accord, and with the full understanding of all matters set forth in the information and in this plea agreement.

21. The Defendant declares that he/she is able to read and that he/she has read and understands everything in this plea agreement; or that he/she cannot read, but everything in this plea agreement has been read to him/her; that he/she understands all of it, and that he/she is satisfied with the advice and services given by his/her attorney, and that no one, including his/her attorney, has compelled or induced him/her to enter this plea by any force, duress, threats or pressure. This plea is being entered into freely and voluntarily by the Defendant.

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE PLEA AGREEMENT, AND AGREE TO ALL THE TERMS AND CONDITIONS SET OUT HEREIN.

_____ _____
Defendant Date

_____ _____
Attorney for the Defendant Date

_____ _____
County Attorney or his/her Assistant Date

_____ _____
Judge of the Fourth Judicial District-MHC Date

CERTIFICATE OF DEFENDANT'S ATTORNEY

I, Defendant's counsel of record, certify that: I have discussed this case with the Defendant, including the nature of the charges, essential elements of each, the evidence against him/her of which I am aware, the possible defenses he/she has, the maximum penalty for the charges and the facts as set forth in the State's information or on the record. I believe he/she fully understands this plea agreement, the consequences of entering it, and that the Defendant does so of his/her own free will. In my opinion, the Defendant is mentally competent.

_____ _____
Attorney for Defendant Phone # Date

SOUTHWEST IOWA MENTAL HEALTH COURT APPLICATION

FOURTH JUDICIAL DISTRICT
SOUTHWEST IOWA MENTAL HEALTH COURT
COUNCIL BLUFFS, IOWA

APPLICATION AND ADMISSION SCREENING

Name:_____ Date:_____

Address:_____ SSN:_____

_____ Sex/Race:_____

Telephone Numbers: Home:_____ Work:_____

Birthdate:_____ Age:_____ Work#:_____

E-mail _____

Legal History

Current lawyer: _____

Charges pending in what jurisdictions: _____

_____

If yes, please list:

	Charged With	Where	Date	Status
1.				
2.				
3.				
4.				
5.				

(**Criminal History**: See attachment-provided by CA)

Are you on Probation or Parole? Yes or No PO's Name_____

SOUTHWEST IOWA MENTAL HEALTH COURT APPLICATION

Are you a sex offender or currently facing sex based charges (under Chapter 709 of Iowa) or any other jurisdiction? Yes _____ No _____

Additional contacts for the Applicant:

Name Relationship Phone Number

1._____

2._____

Mental Health History

Mental Health Diagnosis (if known)?_____

Last Mental Health Hospitalization? (Date and Hospital if known)_____

Substance Abuse Issue? Yes or No
If yes, what is substance of choice?_____

Intellectual Disability? Yes or No

Traumatic Brain Injury? Yes or No
If Yes, what year did the injury occur? _____

Date:_____ _____
Defendant (signature)

Date:_____ _____
Attorney for Defendant (signature)

SOUTHWEST IOWA MENTAL HEALTH COURT APPLICATION

Interagency Release of Information Form

AUTHORIZATION FOR DISCLOSURE AND RELEASE OF MEDICAL, MENTAL HEALTH, SUBSTANCE ABUSE, AND/OR CORRECTIONS INFORMATION

Applicant/Participant_____Birthdate_____

I, the undersigned, authorize each of the agencies initialed below whose purpose is to coordinate the services and treatment of participating clients/patients with involvement in mental health, substance abuse, and corrections conditions:

_____ **Heartland Family Services (all services and locations), 515 E. Broadway, Council Bluffs, IA 51503**
_____ **Jennie Edmundson Hospital, 933 E. Pierce St, Council Bluffs, IA 51503**
_____ **Mercy/CHI Hospital, 800 Mercy Dr., Council Bluffs, IA 51503**
_____ **CHI Health Psychiatric Associates, 801 Harmony St, Suite 302, Council Bluffs, IA 51503**
_____ **Pottawattamie County Community Services, 515 5th Ave, Suite 113, Council Bluffs, IA 51503**
_____ **Southwest Iowa MHDS Region, 515 5th Ave, Suite 113, Council Bluffs, IA 51503**
_____ **Pottawattamie County Sheriff's Office, 1400 Big Lake Rd., Council Bluffs, IA 51501**
_____ **Pottawattamie County Jail, 1400 Big Lake Rd, Council Bluffs, IA 51501**
_____ **Council Bluffs Police Dept., 227 S. 6th St, Council Bluffs, IA 51501**
_____ **Department of Corrections, Adult Probation, 801 S. 10th St, Council Bluffs, IA 51501**
_____ **PDO or attorney of record; County Attorney; and other member of MHC team**
_____ **Lasting Hope Recovery Center, 415 S. 25th Omaha NE 68131**
_____ **Collaborative Support Team, 515 5th Ave, Suite 113, Council Bluffs, IA 51503**
_____ **Heartland Bridges, 600 9th Ave, Council Bluffs, IA 51503**
_____ **Other:_____(family member and/or significant other must include address)**
_____ **Other:_____(must include name and/or agency and address)**
_____ **All of the Above Providers**

To disclose verbally and/or to release in writing to any and all of the participating agencies initialed above, the following information pertaining to the evaluation and/or treatment of the above-named client/patient: (please checkmark)

_____ **Attendance and Compliance**
_____ **Discharge Summary**
_____ **History and Physical**
_____ **Medical/Health**
_____ **Lab, X-Ray, EKG**
_____ **Progress Notes**
_____ **Diagnosis & Assessment (for both mental/substance)**
_____ **Insurance coverage/funding sources**
_____ **Emergency Room Report**
_____ **Pathology Report**
_____ **Consultations**
_____ **Educational records**
_____ **Other information as needed (specify)**
_____
_____ **On-going progress communication**

SOUTHWEST IOWA MENTAL HEALTH COURT APPLICATION

This information is to be used for the coordination of the applicant/participant's mental health, substance abuse, and corrections conditions. This information is gathered for the purpose of evaluating criteria for admission into Mental Health Court; preparing a case plan for Mental Health Court and to check progress and compliance with the terms of Mental Health Court. I understand that redisclosure of this information by the authorized participating agencies is prohibited, except as permitted by applicable federal and state laws. Once the requested information has been disclosed, the recipient of the information may re-disclose it and the privacy regulations guaranteed with this consent to release information, may no longer protect the information. However, filings with the Clerk of Court will have a level of security to prevent public access.

This authorization will automatically expire in twelve (12) months from the date of my signature, except as hereby specified: _____(list specific number of days or months). At that time, no express revocation shall be needed to terminate my consent, but I understand that I may revoke this consent at any time by sending a written notice to the Director of Medical Records of each of the participating agencies whom I have authorized above. I understand that any disclosure or release of information which was made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality and that my protected health information may be subject to redisclosure and may no longer be protected by the HIPAA privacy provisions. I further understand that I may inspect the information disclosed by any of the participating agencies by contacting the Director of Medical Records at each such agency. I understand that a medical release is normally 6 months but by my voluntary participation in Mental Health Court-the supervision has a minimum of 12 months. This authorization will automatically expire upon the completion of correctional supervision (institutional or community based).

I understand that if the person or entity listed above is a physician; surgeon; physician's assistant; advanced registered nurse practitioner or mental health professional this authorization also permits _____ to consult with the provider about my medical history and condition relating to my diagnosis; evaluation; treatment; progress notes; attendance and compliance (with medication as well as other therapeutic treatment);and any other information relied upon which bears upon conditions of eligibility; conditions of care plan; or progress/compliance for the Southwest Iowa Mental Health Court.

_____ _____

Signature of Mental Health Court applicant/participant **Date**

_____ _____

Attorney for Applicant/participant **Date**

SOUTHWEST IOWA MENTAL HEALTH COURT APPLICATION

Specific Authorization For Release Of Information

Protected by State Or Federal Law, 42 CFR Part 2

I specifically authorize the release of information relating to:

(Applicant/participant must initial appropriate line(s))

____ Substance Abuse (alcohol/drug abuse)
____ Mental Health (including psychological testing)
____ Acquired Immune Deficiency Syndrome (AIDS) including Human Immunodeficiency Virus (HIV) test results

_____
Signature/Date

In Order For The Above Information To Be Released, You Must Sign Here <u>And</u> In the Next Column.

_____
Signature of applicant/participant or Authorized Representative

_____
Relationship, if not the applicant/participant

_____
Address

_____
Date

Copy given to applicant/participant on _____(date)

by _____

Information released on _____(date)

by_____

to _____
_____

SOUTHWEST IOWA MENTAL HEALTH COURT APPLICATION