LENEXA MUNICIPAL COURT
MENTAL HEALTH DIVERSION APPLICATION

Lenexa Municipal Court 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:

- 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 (ROI) between JCMH and Lenexa Municipal Court throughout the duration of diversion

How to Apply:

Application Packets are available from the Lenexa Prosecutor as well as Municipal Court Judges. Please return completed packets to the court clerks for filing.

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

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

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PERSONAL INFORMATION

FULL LEGAL NAME: _____ MAIDEN NAME: _____

PREFERRED TO BE CALLED: _____

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

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?

_____

_____

HOME NUMBER: _____ CELL NUMBER: _____ WORK NUMBER: _____

DRIVER'S LICENSE NUMBER and STATE: _____ CDL? _____

EMPLOYMENT/EDUCATION INFORMATION

Please indicate your highest level of education completed: _____

Employer: _____ Address: _____

Job Title: _____ How Long: _____

Salary: _____

Past Employer: _____ Address: _____

Job Title: _____ How Long: _____

Salary: _____ Reason Left: _____

CRIMINAL HISTORY INFORMATION

Please list all prior Juvenile and Adult incidents, arrests, convictions, diversions and/or juvenile adjudications including any offenses expunged, plea bargained or dismissed. ALL CRIMINAL HISTORY MUST BE INCLUDED. Failure to provide accurate criminal history information on this application may result in the denial of your diversion application or the revocation of your diversion.

DATE	CHARGE(S)	LOCATION	OUTCOME/DISPOSITION

MEDICAL HISTORY

Do you currently receive Medicaid/Medicare Disability benefits? YES ☐ NO ☐

Have you ever participated in Mental Health Treatment? YES ☐ NO ☐

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What is your diagnosis? _____

Are you receiving Mental Health Treatment currently? YES ☐ NO ☐

When: _____ Where: _____

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

Lenexa Municipal Court, Lenexa Prosecutor's Office, and A Connecting Pointe

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

Address _____ City/State _____ Zip Code _____

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.