INITIAL INFORMATION FORM
PLEASE PRINT CLEARLY AND RETURN TO THE SECRETARY

TODAY'S DATE: _____

NAME: _____
(Last) (First) (Middle Initial)

☐ MALE ☐ FEMALE

AGE: _____ DATE OF BIRTH: _____

SOCIAL SECURITY NUMBER: _____

PLACE OF BIRTH: _____

RACE: ☐ WHITE ☐ BLACK ☐ ASIAN ☐ AMERICAN INDIAN ☐ HISPANIC

☐ OTHER _____

MARITAL STATUS: _____

HEIGHT: _____ WEIGHT: _____ EYES: _____ HAIR: _____

REQUEST FOR CONSIDERATION IN MICAP
EIGHTEENTH JUDICIAL CIRCUIT
DuPAGE COUNTY, ILLINOIS

NAME OF DEFENDANT _____

ADDRESS OF DEFENDANT _____

_____

CASE NUMBER(S) _____

ATTORNEY'S NAME AND PHONE NUMBER _____

MICAP is primarily a diversion program. In order to apply for the MICAP the applicant must meet the following criteria:

- Applicant must be 17 years of age or older and have an adult criminal case in DuPage County.
- The offense charged is a misdemeanor or nonviolent felony case
- Must have Axis I Major Mental Illness (per DSM-IV-TR or DSM-V)
- Applicant must be appropriate for and amenable to mental health treatment
- Applicant must refrain from illicit drug use, alcohol use and non-prescribed drug use as a condition of participation
- Applicant must demonstrate that the Mental Illness is a contributing or motivating factor in the criminal activity that brought them into the criminal justice system. Please explain: (diagnosis, how the illness/disorder relates to the charges).

_____
_____
_____
_____
_____
_____
_____

- Applicant must be a resident in DuPage County or intend to remain in the county for the length of MICAP Supervision.

If all above criteria is met, the applicant should complete the Preliminary Information Sheet and review and sign the Release of Confidential Information form. The matter should be given a status date in Court Room 4001, per the MICAP application procedure. Please attach any psychiatric/psychological/mental health treatment records that would aid the MICAP team in assessing the applicant's eligibility.

DuPage County MICAP
PRELIMINARY INFORMATION SHEET

DATE: _____

DEFENDANT'S NAME: _____

Case No._____ Charges: _____

NCD: _____CTRM: _____

Does the applicant live in DuPage county? ☐ NO ☐ YES Address_____

_____

Is the applicant currently on probation, parole, or pre-trial supervision? ☐ NO ☐ YES - If YES,

where:_____ with officer:_____

Is the applicant a veteran? ☐ NO ☐ YES

Applicant's diagnosis (if known): _____

Name and address of Defendant's mental health provider (if known): _____

_____

Date of last appointment attended with MH provider: _____

Defendant's attorney's name: _____ Phone: _____

Do you have health insurance? ☐ NO ☐ YES - If YES: ☐ private insurance ☐ Medicare

☐ employer plan ☐ parent's plan

Insurance company's name: _____ Policy #_____

Contact Information

Home Phone: _____ Cell Phone: _____

Email: _____

Employer: _____

Work Address: _____

Work Phone: _____

An applicant packet must be completed and turned in to the probation department. No part of the MICAP application packet should be filed in court. Please see MICAP Application Procedures for more info.

THE MICAP ORDER MUST BE ENTERED IN OPEN COURT WITH THE DEFENDANT PRESENT AND BOND RECORD COMPLETED.

A COPY OF THE SIGNED ORDER MUST BE PROVIDED TO THE MICAP OFFICE BEFORE THE CASE WILL BE CONSIDERED.

DUPAGE COUNTY MENTAL ILLNESS COURT ALTERNATIVE PROGRAM
Ongoing Release of Confidential Information

I have asked to participate in the Mental Illness Court Alternative Program ("MICAP"). I understand that I am required to accept treatment, including psychotropic medication, case management and/or other services in order to participate in this program, and that these treatments and other services are described in my Court-mandated treatment plan and are conditions of my bond.

I understand that information regarding my attendance and progress in treatment is protected by federal and state law and regulations. As a condition of participating in MICAP, however, I will waive these protections as provided in this release.

I authorize the staff of MICAP and the providers of the services described in my treatment plan to release and share information with each other and with my attorney, the MICAP judge, the DuPage county State's Attorney's Office, the DuPage County Department of Probation and the Health Department case manager and outcome component statistician. They may share information on my treatment plan, diagnosis, previous outpatient treatment and/or hospitalizations, medications or other rehabilitation efforts as well as my progress in treatment, medication compliance, attendance and degree of participation in treatment programs and other services described in my treatment plan, compliance with the rules of any programs or services described in my treatment plan, dates and results of urinalysis or blood testing, prognosis and termination or completion of treatment or any services described in my treatment plan. Background information regarding prior mental health treatment and jail/prison experiences and police contacts may be required from me for statistical documentation. If any providers of treatment or other services described in my Court-mandated treatment plan request that I sign additional consents, waivers or releases authorizing them to disclose or share any information related to the treatment plan or *my* participation in MICAP, I will do so.

The reasons this information needs to be released and shared are:

- to allow this staff of MICAP and the providers of treatment and other services described in my treatment plan to coordinate treatment and services with each other;
- to enable the judge and staff of MICAP, my attorney, the DuPage County State's Attorney's Office and the DuPage Department of Probation to monitor whether I am in compliance with all the terms of my bond and the orders issued by the MICAP Judge, and MICAP Participation Guidelines;
- to enable the staff and the judge of the DuPage Mental Health Court to make informed decisions regarding ongoing treatment planning, my continuing participation in the MICAP program and the outcome of my criminal case.

My consent for the release, sharing and re-disclosure of the information described above is limited to these purposes. I understand that the recipients of this information may use it only in connection with their official duties and with respect to the terms of my MICAP-mandated treatment plan and the statistical outcome component of MICAP.

I understand that the information released and shared may result in modifications to the terms of my bond Court orders and/or mandates and/or the terms of my participation in a treatment program of other services. I also understand that this information may affect the outcome of pending criminal matters or the conditions of my release pending criminal proceedings or sentencing.

I understand that this consent to release and share confidential information is required for me to participate in the Mental Illness Court Alternative Program. This consent will remain in effect for a period not to exceed one year. This consent cannot be revoked by me until I have completed the Court-mandated treatment plan or have been terminated from MICAP. However, if I revoke this or fail to sign a new release to cover any time I will be in violation of the terms of my bond and subject to a petition to revoke bond.

_____
NAME OF DEFENDANT

THIS RELEASE IS IN EFFECT FROM TIME OF SIGNING UNTIL
_____ (NO MORE THAN 1 YEAR FROM TODAY)

_____
SIGNATURE OF DEFENDANT

_____
DATE

WITNESS: _____

DATE: _____

CASE NUMBER: _____