COBB COUNTY MENTAL HEALTH COURT REFERRAL

Date: _____ Case No(s). _____

Defendant Name: _____DOB:_____

Address: _____Email: _____

Gender: (Circle one) Male / Female / Other Marital Status: ___Married ___ Divorced ___ Single ___ Widowed

In Custody? (Circle one) YES / NO If out of custody, Phone Number: _____
Current Charge(s):
_____
_____

Attorney: _____Phone: _____

Attorney Email Address: _____

Any Other Pending charges? (Include all felonies/misdemeanors, county, arresting agency, any additional info)
_____
_____
_____

Prior Mental Health Treatment History? **What year(s)? _____**
Official Mental Health Diagnosis _____
Name of Diagnosing Agency_____
Please attach mental health records or documentation of diagnosis.

POTENTIALLY DISQUALIFYING CHARACTERISTICS (*check if applicable)*
_____Current Sex Offender (Actively on Sex Offender Registry) or Current Charge is a "Serious Violent Felony" as listed in O.C.G.A. 17-10-6.1 OR a "sexual offense" as listed in O.C.G.A. 17-10-6.2
_____No Cobb County Residence
_____Current charge(s) involve drug trafficking or distribution.
_____Cognitive, functional, or medical condition that would prevent full participation in MHC.
_____Currently in residential treatment or serving time in prison
_____New charge carries a minimum sentence of *less than* 3 years OR if probation violation, less than 3 years left on probation.

PRESUMPTIVE QUALIFYING CHARACTERISTICS
_____Was the commission of the offense perpetuated by a mental health crisis or episode?
_____Willing to voluntarily enter the Mental Health Court program and follow all special conditions?
_____Willing to complete a Mental Health Court application packet and/or undergo psychological testing?
_____Currently resides (or will reside) in acceptable housing in Cobb County.
_____Currently on probation or parole anywhere other than Cobb County? Where? _____

****Defendant, through counsel, hereby requests that the MHC staff interview and assess Defendant to determine if eligible for the MHC program. ****

_____ _____
Defense Attorney *(signature)* **Print**

****Please email completed referral to the MHC Coordinator: MHC.App@cobbcounty.gov**

IMPORTANT: *All Information obtained during the course of this preliminary intake and assessment will be kept confidential. None of the information will be used in any ongoing prosecution of a pending case or probation surrender. *Final determination about MHC eligibility will be decided after review of all relevant information. Please submit any additional information you would like considered along with this MHC Referral Form.*

Additional Information from Defense Attorney:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

ASSISTANT DISTRICT ATTORNEY REVIEW ONLY

REVIEWED BY: _____

____ RECOMMEND FOR STAFFING **___ DOES NOT RECOMMEND FOR STAFFING**

Has the victim been contacted? _____
Do they support defendant being in the program? _____
Is restitution an issue? _____

Additional Information from Assistant District Attorney (including explanation for "no" recommendation):

_____
_____
_____
_____
_____
_____
_____
_____
_____

Once ADA Review is complete, email scanned copy to MHC, Melanie Valentine at melanie.valentine@cobbcounty.org.

MHC OFFICE REVIEW ONLY

Referral Rec'd By: _____
Referral Rec'd Date: _____
Referral to ADA Date: _____
Date Full Application Rec'd _____
Plea Date: _____

Date Rec'd from ADA: _____
Date Client Screened: _____
Staffing Date: _____
Rejection Letter Date: _____