**Referral to CBI Diversion Program**

**Date: **

**Participant’s Name:  DOB: **

**Address:  Contact #: **

**To be completed by Referring Attorney:**

Attorney Name (Printed):  Signature: 

Contact Number: Fax:  Email: 

Participant to attend intake on:  @ 

(See Flyer for available intake appointments)

Reason for Referral: (Provide a detailed overview of why the participant is being referred including the charges and agreement made)





I agree to participate in the CBI Diversion Program and understand the agreement mentioned above. I will attend the scheduled intake appointment.

Participant Signature:  Date: 

**To be completed by the District Attorney’s Office:**

Assigned A.D.A Name (Printed): Signature:

Contact Number: Email:

Compliance Date:

**To be completed by CJRC Staff:**

Attended scheduled intake appointment and scheduled to begin classes on:

Failed to attend scheduled intake appointment or make contact within 30 days.

Outreach attempts:

**Send Referral Form and Consent Form to CJRC**

Attention: Robin Heath

Fax: 919-560-0504 Tel: 919-560-0500

**Consent for Communication of Confidential Information Among Cognitive Behavioral Intervention (CBI) Core Team Members**

I,  hereby authorize the 14th Judicial District’s Cognitive Behavioral Intervention (CBI) team members to disclose to, and receive information from the following parties:

* Presiding Judge
* Representative of the District Attorney’s Office
* Private Attorney:
* Other:

The purpose of the disclosures is to inform the team members of my progress in the CBI program. The information disclosed may include my initial screening for the program, the case management assessment, case management plan, progress in the CBI program, notes, attendance, participation, attitude, additional evaluations or referrals.

Disclosure of this confidential information may be made only as necessary for, and pertinent to, hearings, and/or reports concerning the charges relevant to my participation in the CBI program. The docket number(s) for these charges are:

Date Charge Docket

Charged Offenses Level Number

   

   

   

I understand this consent will remain in effect for no more than one year and cannot be revoked by me until there has been a formal and effective termination of my involvement with the CBI program such as graduation, termination, or formal withdrawal.

 

Date Participant Signature

**Revocation of Authorization**

I do hereby request the authorization to disclose confidential information of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Client Name*

signed by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Name of Person who signed Authorization* *Date of original signature*

be rescinded for the person(s), organization, or others checked off below,

effective\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. I understand that any action taken on this authorization prior to the rescinded date is legal and binding.