

19th District Hybrid DWI/Drug Treatment Court (HDDTC) Transfer Packet

Instructions and Explanations, Referral Process,
Initial Eligibility Requirements, and Intake Form

Completed Referral Packets should be sent to the HDDTC Program Coordinator:

Email: HDDTC@dearborn.gov

Fax: 313-943-2690

Phone: 313-943-3059

HDDTC Instructions and Explanations

1. **Plea/Disposition:** The transferring court must enter a plea of Guilty or No Contest. This can take place before or after the referral.
2. **Referral to HDDTC:** Referrals may come from any District or Municipal court in the State of Michigan that is willing to transfer the case(s). The Initial Eligibility Requirements Checklist and the Intake Form (in this referral packet) must be completed and forwarded to the program coordinator for a referral to be considered.
 - a) Referral sources include: Court/Judicial, Prosecutor, Defense Attorney, Self, Probation/Parole, etc.
 - b) Upon referral, the program coordinator will use the information provided in the referral packet to contact the transferring court and obtain the following:
 - Police Report
 - LEIN/CCH including warrant check and driving record
 - Register of Actions
 - Plea Agreements
 - Prosecutors Contact Information
 - c) The Agreement and Waiver of Rights, Multiple Party Release of Information, and Phase Sheet will be forwarded to the defendant and defense attorney (if applicable) to review. The HDDTC Program Coordinator will go over these documents with the defendant and if the defendant chooses to participate in the program, the defendant must sign the documents at this time.
3. **HDDTC Evaluation:** If the defendant meets initial eligibility requirements, a program evaluation is required to determine program eligibility and will be scheduled with an HDDTC probation officer. This evaluation may take up to three hours to complete.
4. **Clinical Evaluation:** In addition to a program evaluation, the defendant is also required to participate in a clinical evaluation with one of the HDDTC's partnered treatment providers. This evaluation may take up to three hours to complete.
 - a) If the defendant is already in treatment and wishes to stay with their current treatment provider, the following conditions must be met:
 - Defendant signs a release with current treatment provider
 - The biopsychosocial must be forwarded to the HDDTC program coordinator
 - Provide proof of an established relationship with current treatment provider
 - Current treatment provider is willing to forward monthly progress and attendance reports and maintain open communication with the program
 - Current treatment provider has at least one of the following credentials:
 - Licensed Master Social Worker (LMSW) with specialty in SUD (on a developmental plan) – must be supervised by someone with a CAADC Certification;
 - Certified Alcohol and Drug Counselor (CADC);
 - Certified Advanced Alcohol and Drug Counselor (CAADC);
 - Internationally Certified Alcohol and Drug Counselor (ICADC); and/or
 - Internationally Certified Advanced Alcohol and Drug Counselor (ICAADC).
5. **Acceptance/Denial:** A Referral Form will be completed indicating whether the defendant has been accepted or denied (if denied, an explanation will be provided) and forwarded to the transferring court.
 - a) If accepted, a PSC Memorandum of Understanding, Transfer of Jurisdiction under MCL 600.1088 will be included and signatures of the listed parties will be required.

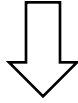
HDDTC Instructions and Explanations (**Continued**)

6. **Transferring Court Sentencing:** Sentencing at the transferring court should be completed before being sentenced at the receiving court. The defendant must be sentenced to the following minimum sentencing requirements:
 - a) Ordered to complete the 19th District HDDTC program as part of the probation conditions.
 - b) A PSC Memorandum of Understanding, Transfer of Jurisdiction signed by all listed parties being received.
 - c) Sentenced to a minimum of 18 months of reporting probation.
 - d) Financial assessments to be determined by the transferring court. Payments will be collected at the receiving court.
 - e) The transferring court is responsible for forwarding the receiving court an updated Register of Actions, Order of Probation and plea agreements.

7. **HDDTC Sentencing:** After the defendant has been sentenced at the transferring court, the defendant will be scheduled to be sentenced/admitted into the HDDTC program.
 - a) \$720.00 in Probation Oversight fees and \$90.00 in Assessment fees must be assessed.

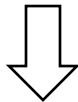
HDDTC Referral Process Flow-Chart

Determine initial eligibility (see page 5). If eligible, complete the intake form, contact program coordinator and send completed information.



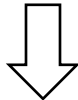
Referring court forwards all required documents to program coordinator (See list of required documents on page 2).

***Note: The defendant will not be scheduled for an evaluation if all necessary information is not received.

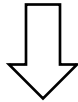


Defendant meets with:

1. HDDTC Program Coordinator to go over program documents,
2. HDDTC probation officer for program evaluation,
3. HDDTC's partnered treatment providers for a clinical evaluation.



If the defendant is programmatically and clinically eligible, the HDDTC will send a completed referral form and a PSC Memorandum of Understanding (MOU), Transfer of Jurisdiction under MCL 600.1088 to the originating court for signature.



Defendant is sentenced at the originating court with minimum sentencing requirements.
Transfer MOU is received and contains all required signatures.
The HDDTC will schedule the defendant to be admitted into the program.

It is important to not deviate from the steps outlined, above. If you have any questions or concerns regarding the transfer process, please reach out to the HDDTC program coordinator at HDDTC@dearborn.gov or call 313-943-3059

Initial Eligibility Requirements

All requirements below must be met to determine initial eligibility. If a defendant meets all initial eligibility requirements, they must participate in a program evaluation with an HDDTC probation officer and clinical evaluation with a partnered treatment provider to determine **full program eligibly**.

1. Is the defendant a Wayne County resident? Or willing to relocate to Wayne County before program evaluation?	Yes – Move to #2	No – Defendant may not participate in the program
2. Does the defendant reside in or is willing to relocate to a clean and sober living environment?	Yes – Move to #3	No – Defendant may not participate in the program
3. Is the defendant 18 years of age or older?	Yes – Move to #4	No – Defendant may not participate in the program
4. Is the defendant's case a misdemeanor (or felony being reduced to a misdemeanor) from a District or Municipal Court?	Yes – Move to #5	No – Defendant may not participate in the program
5. Does the prosecutor have any objections to this person participating in the program?	No – Move to #6	Yes – Defendant may not participate in the program
6. Does the defendant want to participate in the program?	Yes – Move to #7	No – Defendant may not participate in the program
7. Is the defendant a violent offender or convicted sex offender? (DV cases may be accepted on a case-by-case basis)	No – Move to #8	Yes – Defendant may not participate in the program
8. Is the current offense related to the use or addiction to alcohol and/or drugs? (Ex: OWI, Larceny, Retail Fraud, Poss. Of Controlled Substance, etc.)	Yes – Move to #9	No – Defendant may not participate in the program
9. Is the defendant currently charged with or has pled guilty/been convicted of Manufacturing/Delivering/Possessing with intent to Manufacture/Deliver/Possess any controlled substance within the past 10 years?	No – Move to #10	Yes – Defendant may not participate in the program
10. If currently prescribed a controlled substance, is the defendant willing to discontinue the use of controlled substances, after consulting with a physician, but before admission into the program?	Yes – Move to #11	No – Defendant may not participate in the program
11. Does the defendant have open warrants?	No – Complete referral packet	Yes – Defendant must get warrant lifted before admissions is considered

HDDTC Intake Form

Office use only

Referral Date: _____

Referral Source: _____

Defendant Contact Information:

Name: _____ DOB: _____ Last 4 SSN: _____

Address: _____

Phone #: _____ Email: _____

Substance of Choice: _____ Date of last use: _____

Case/Court Information:

Charge(s): _____

Case #(s): _____

Judge: _____

Next Hearing Date/Time: _____ Hearing Type: _____

Transferring Court Name/location: _____

Contact Person: _____

Phone #: _____ Email: _____

Attorney Contact Information:

Name: _____ P#: _____

Phone #: _____ Email: _____

Emergency Contact:

Name: _____

Relationship: _____ Phone Number: _____

Employment: *(check all that apply)*

*** We will not contact your employer ***

Are you currently employed: Yes ____ No ____

If yes, are you: Full-time ____ Part-Time ____ Number of hours worked per week: _____

Employer: _____

HDDTC Intake Form (**Continued**)

Defendant Demographics: *(check all that apply)*

Gender: Male ___ Female ___ Non-Binary ___ Unknown ___
Prefer not to answer ___ Other _____

Pronoun: He/Him ___ She/Her ___ They/Them ___ Unknown ___
Prefer not to answer ___ Other _____

Ethnicity: Hispanic or Latino/a ___ Non-Hispanic or Latino/a ___ Unknown ___
Prefer not to answer ___

Race: African American/Black ___ American Indian/Alaska Native ___ Arab American ___
Asian ___ Middle Eastern ___ North African ___ White ___ Unknown ___
Prefer not to answer: ___ Multi-Racial ___ Other _____

Employment: *(check all that apply)*

***** We will not contact your employer *****

Are you currently employed: Yes ___ No ___

If yes, are you: Full-time ___ Part-Time ___ Number of hours worked per week: _____

Employer: _____

Health Insurance Information: *(check all that apply)*

Do you have health insurance: Yes ___ No ___

If yes, who is your provider (EX: Blue Cross, HAP, etc.): _____

Provider Type: Medicare ___ Medicaid ___ Employer ___ Private Insurance ___

Treatment History: *(check all that apply)*

Currently seeing a treatment provider: Yes ___ No ___

If yes, how often: _____

Therapist's name _____

Therapist's contact information: _____

Facility: _____

HDDTC Intake Form (Continued)

Prescriptions: *(check all that apply)*

Are you currently prescribed any medications: Yes ____ No ____

Do you have a medical marijuana card: Yes ____ No ____

If you are prescribed medications, please list them below:

***** Please send photos of prescription bottles with completed packet*****

Name of Prescription	Reason	Dosage	Frequency	Prescriber