Penal Code 1001.36 Mental Health Diversion Treatment Plan

Participant's Name: _____ **DOB:** _____

Treatment Provider: The above-named person is applying for Sacramento Superior Court's Mental Health Diversion which the Court requires that a person create a Mental Health Diversion Plan. Please complete the information below. You may provide it directly to the participant's attorney of record indicated below by electronic mail or by fax.

To be filled out by the Attorney:

Attorney of Record: _____ Telephone No.: _____

Email Address: _____ Fax No. _____

Provider's Name: _____ Provider's Agency: _____

Provider's Contact Information (phone, email): _____

Patient is suffering from a mental disorder diagnosed as _____

_____

Symptoms include _____

_____

_____

Psychiatric Appointments ☐ **Yes** ☐ **No** How often client to be seen: _____

Psychiatric Medications ☐ **Yes** ☐ **No** If no psych appointments OR no medications, why not?

_____

Individual Therapy ☐ **Yes** ☐ **No** How often client to be seen _____

Group Therapy ☐ **Yes** ☐ **No** Which groups and how often _____

_____

Case Management Meetings ☐ **Yes** ☐ **No** How often client to be seen _____

Substance Use Treatment ☐ **Yes** ☐ **No** Is it in-house or referred out? If not recommended, why not?

_____

_____

Next Appointment(s): Psychiatry _____ Therapy _____ Case Management _____

Other recommendations (please explain): _____

_____

_____

_____

_____

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Evaluation completed by: _____

Credentials and other relevant work history: _____

_____

_____

_____

I have reviewed this plan with patient and patient agrees to comply with the plan. Based on the above diagnoses, patient's symptoms would respond to the above treatment recommendations. The Court reserves the right to request additional information as needed.

Signature of Agency Representative	Print Name	Date
Signature of patient	Print Name	Date