STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

Office of Forensic Mental Health • Behavioral Health Administration

Address

Date

Client Name	Cause Number	Date of Birth

Section 1. Recommendation for Forensic Diversion Program

This recommendation is based on an interview with the individual and a review of available records related to previous competency restoration services.

RCW 10.77.610(4) states: Individuals who are referred to a diversion program described in this section shall have a forensic navigator assigned to assist them for up to six months while engaging in the services described in the diversion program.

Based on the Diversion Navigator's observations of an individual's willingness to work with available services and review of any available records, the Diversion Navigator:

☐ Recommends Forensic Navigator Diversion Program

☐ Does Not Recommend Forensic Navigator Diversion Program

Please Note: Although this is the Diversion Navigator's determination related to the Forensic Diversion Program suitability, the final decision is made by the court. In addition, this determination DOES NOT include an assessment of community risk/community safety.

Client's willingness to participate in available services

FHARPS

FPATH

Behavioral Health Treatment or ☐ N/A

Substance Use Disorder Treatment or ☐ N/A

Housing (where will the individual stay if release from custody)

Transportation (how will the client get to recommended services and/or related appointments)

Section 2. Assisted Outpatient Treatment

Based on the Diversion Navigator's observations of an individual's willingness to work with available services, review of any available records, and review of the individual's history of participation in outpatient services, the Diversion Navigator:

☐ Recommends this individual for Assisted Outpatient Treatment

☐ Does not recommend this individual for Assisted Outpatient Treatment

Should the court dismiss these charges, the Diversion Navigator will initiate the process to petition this individual for Assisted Outpatient Treatment.

Signature	Date	Time
		: ☐ A.M. ☐ P.M.

Printed Name	Position