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| Text  Description automatically generated | OFFICE OF FORENSIC MENTAL HEALTH SERVICES (OFMHS)  **Diversion Navigator Interview** | | | | |
| **Individual Information** | | | | | |
| INDIVIDUAL’S NAME (LAST, FIRST, MI) | | | | | DATE OF BIRTH (MM/DD/YYYY) |
| INTERVIEW DATE AND TIME  Date: Time:  AM  PM Duration: | | | | INTERVIEW LOCATION (PLACE / VIRTUAL) | |
| ATTORNEY PRESENT  No  Yes; if yes, attorney name: | | | | | |
| **Purpose of Diversion Navigator Interview** | | | | | |
| Diversion Navigators explained purpose of visit to support individual in becoming stable and avoiding additional court-ordered competency evaluations under RCW 10.77 with the goal to divert individuals from the competency process and receiving additional criminal charges by offering wrap around services. Diversion Navigator explained role as officer of the court and informed individual information that is shared could be requested by court and encouraged individual to not discuss anything related to their current charges or events leading up to current charges.  Yes  No  Other: | | | | | |
| Additional information, if needed: | | | | | |
| **Demographics** | | | | | |
| **IDENTIFIED RACE / ETHNICITY (CHECK ALL THAT APPLY):**  White  Black or African American  American Indian or Alaska Native  Asia  Native Hawaiian or Other Pacific Islander  Hispanic or Latin(x)  Non-Hispanic or Latin(x)  Two or more races  Unknown  **TRIBAL STATUS:**  Yes  No  Unknown  **VETERAN STATUS:**  Yes  No  Unknown  **DDA STATUS:**  Yes  No  Unknown | | | **DISABILITY STATUS:**  Physical disability  Mental disability  Both physical and mental disability  No disability  Unknown  **MEDICAL INSURANCE STATUS:**  Medicaid  Medicare  Dual Medicaid and Medicare  Private insurance  Veteran’s insurance  Veteran’s Administration  None  Unknown  **IDENTIFICATION STATUS:**  Valid driver’s license  Not valid driver’s license  Suspended / revoked driver’s license  Valid Identification  None  Unknown  **TRANSPORTATION STATUS:**  Public transportation  Hopelink  Paratransit  Private vehicle  Other: | | |
| **Housing Status (Required)** | | | | | |
| Homeless  Unstably Housed  Stably Housed | | Current / Potential Housing and Contact Information: | | | |
| FHARPS ELIGIBLE  Yes, Forensic Navigator explain FHARPS Services and referral will be made.  No  Other: | | | | | |
| FPATH ELIGIBLE  Yes, Forensic Navigator explain FPATH Services and referral will be made.  No  Other: | | | | | |
| **Mental Health Presentation** | | | | | |
| PRESENTING SYMPTOMS (SYMPTOMS OBSERVED BY DIVERSION NAVIGATOR) | | | | | |
| SYMPTOMS STATED BY INDIVIDUAL | | | | | |
| **Current Behavioral Health Treatment** | | | | | |
| CURRENT PRESCRIBED AND TAKING MEDICATIONS  Yes  No  Additional information: | | | | | |
| CURRENT BEHAVIORAL HEALTH PROVIDER IN THE COMMUNITY | | | | | |
| PREVIOUS BEHAVIORAL HEALTH TREATMENT  Yes  No  Individual states: | | | | | |
| **Substance Use** | | | | | |
| CURRENTLY PRESCRIBED AND TAKING MEDICATIONS  Yes  No  Individual states: | | | | | |
| PREVIOUS TREATMENT FOR SUBSTANCE USE  Yes  No  Individual states: | | | | | |
| **Mental Health Presentation** | | | | | |
| CURRENTLY EXPERIENCING SELF-INJURIOUS BEHAVIOR(S) / SUICIDE IDEATION  Yes  No  Unknown  Additional information: | | | | | |
| PREVIOUS SUICIDE ATTEMPTS  Yes. If yes, provide additional information reported.  No  Unknown  Additional information: | | | | | |
| CURRENTLY EXPERIENCE HOMICIDAL IDEATION  Yes. If yes, provide additional information reported.  No  Unknown  Additional information: | | | | | |
| PER THE FORENSIC NAVIGATOR OBSERVATIONS, INDIVISUAL IS CURRENTLY EXPERIENCING SYMPTOMS THAT MAY IMPARE ABILITY TO CARE FOR THEMSELVES  Yes. If yes, provide additional information observed.  No  Unknown:  Additional information and concerns observed: | | | | | |
| IF SAFETY CONCERNS WERE IDENTIFIED, WERE REFERRALS MADE TO APPROPRIATE JAIL OR COMMUNITY-BASED INTERVENTION SERVICES FOR FOLLOW UP?  Yes  No  Unknown  Additional information: | | | | | |
| **Resources and Supports** | | | | | |
| INDIVIDUAL IS CURRENTLY CONNECTED TO ANY OF THE FOLLOWING SUPPORTS  DDA  SSA  CMH / SUD Program  ALTSA  DCYF  VA  CSO  PACT | | | | | |
| NATURAL SUPORT SYSTEM  Individual states: | | | | | |
| STRENGTHS  Individual states: | | | | | |
| **Additional Personal Information** | | | | | |
| RELEVANT CULTURAL FACTORS (SPIRITURAL, ETHNIC, ETC.) **IS THERE ANYTHING SPECIFIC ABOUT YOU THAT YOU WANT TO SHARE?**  Client states: | | | | | |
| LANGUAGE AND/OR CULTURE BARRIERS TO DAILY FUNCTIONING / RESOURCES?  Yes. If yes, provide additional information.  No  Additional information: | | | | | |
| **AOT Eligibility** | | | | | |
| Is willing to follow all services on the Recommended Diversion Plan for the next six (6) months including adherence to prescribed medications and abstaining from alcohol and unprescribed drugs:  Yes  No  Other: | | | | | |
| Additional information: | | | | | |