ELIGIBILITY REFERRAL/TREATMENT PLAN
SUPERVISED DIVERSIONARY PROGRAM
JD-AP-149 Rev. 5-11
C.G.S. § 54-56*l*

STATE OF CONNECTICUT
SUPERIOR COURT
COURT SUPPORT SERVICES DIVISION
www.jud.ct.gov/cssd

Referring Agent *(CSSD Employee)*	Telephone number	Information needed by *(date)*

Name and address of provider requested to complete clinical needs assessment and recommend a treatment plan if eligible

Name of person being referred	Telephone number	Date of referral

Address of person being referred

CSSD is referring the individual named above to your agency for a clinical needs assessment to determine if he or she has a mental or emotional condition, other than solely substance abuse, that (1) has substantial adverse effects on the defendant's ability to function, and (2) requires care and treatment.

If you have any questions regarding this issue, please call the Court Support Services Division (CSSD) employee at the telephone number given above.

Treatment Provider Section

After completion of our assessment and based on the criteria stated above we find:

☐ The individual named above does not qualify for admittance into the Supervised Diversionary Program. *(See attached.)*

☐ Appropriate mental health services and treatment are not available for the individual named above at this time. *(See attached.)*

☐ The individual named above qualifies for admittance into the Supervised Diversionary Program. *(See attached.)*

Signed	Print name of person signing

Agency	Date

Print Form Reset Form