*Case #(s)*_____

McHENRY COUNTY
MENTAL HEALTH COURT
Phone 815/334-4502 Fax 815/334-4691
REFERRAL

Referral must be made within 60 days of first appearance with counsel.

Name: _____ DOB: _____

Phone Number: _____

This individual ☐ is ☐ is not currently an inmate in the McHenry County Correctional Facility.

As a program requirement a participant needs to reside within the boundaries of McHenry County.

This individual ☐ is ☐ is not currently a resident of McHenry County.

Referral from: (Include Contact Information)

☐ Public Defender _____

☐ Private Attorney _____

☐ Other _____

Date of First Court Appearance with Counsel (if known):_____

Additional Information:

_____

_____

_____

Signed _____ Date _____

PLEASE FORWARD THIS REFERRAL TO THE SPECIALTY COURTS DIRECTOR

Original to – Specialty Courts Director – Kelly Scimeca
Copies to – SAO, ATTY
REV 2/2023