Gambling Treatment Referral Program Pilot Project

Pilot Project Location:

Participants:

Time line for Pilot:

Funding: **The pilot program will be implemented through the volunteer efforts of the _____ District Attorney and his staff, the _____ (state) Association on Compulsive Gambling, the Office for Addictive Disorders, and the Office of the Attorney General.**

The Gambling Treatment Referral Program team will immediately begin researching funding opportunities through such sources as grant applications, proposals for legislative funding, and funding through the Compulsive and Problem Gaming Fund.

Short-term objective: **To refer non-violent first or second offenders whose offenses are directly related to gambling addiction into a treatment program. The diversionary program is a cost effective way to reduce the case load in the judicial system, reduce incarceration services, and provide help to the gambling addicts to break the cycle of crime as it relates to gambling.**

Long-term objective **To establish a voluntary statewide diversionary and referral program administered by each District Attorney's office to address criminal activity resulting from pathological gambling.**

Attachment A Package

District Attorney's Cover Letter

The District Attorney's Cover Letter accompanies referral documents that are sent to state ACG.

District Attorney's Referral Form/ACG Acceptance or Denial Form

District Attorney's Authorization to Release Confidential Information to LACG

The Participant signs the release of information to ACG

ACG's Consent/Release to DA

The participant signs the release for ACG to send confidential information to the District Attorney

Judge's or DA'S Cover Letter
To be printed on letterhead

DATE

(treatment organization)

Re: (Defendant's Name)
(Charge)

Dear Mr./Mrs. _____:

The above named individual is being referred to you for an initial assessment to determine whether or not he/she is eligible for services offered through the **District Attorney's Gambling Treatment Referral Program.** Enclosed please find:

1) District Attorney's Referral Form/ACG Acceptance or Denial Form
2) District Attorney's Authorization to Release Confidential Information to ACG
3) ACG's Consent/Release to DA

The above named individual is instructed to contact you at _____, (___)_____ (telephone number), within 72 hours of receipt of this notification to set up an appointment. Thank you for your prompt attention in this matter.

If other information is needed, please contact me at _____.

Sincerely,

_____
Diversion Coordinator/Investigator

District Attorney's Gambling Treatment Referral Form

Date: _____

Defendant/ Participant: _____ **SSN** _____ ☐Male ☐ Female

Charge _____

Attached: Consent Form from District Attorney's Office to ACG
ACG/treatment center's Consent Form to the District Attorney's Office

---

Gambling Treatment Referral Program Acceptance/Denial Form

ACG/center - Center of Recovery

Date of Assessment: _____

Counselor Performing Assessment: _____

Assessment Tools Used:
South Oaks Gambling Screen, DSM-IV Criteria, and Gamblers Anonymous 20 Questions
Reviewed Admissions criteria to A.C.G./ OAD Programs with Participant.

Participant meets criteria for admission to Gambling Treatment Referral Program: ☐**yes** ☐**no**

If not, why? _____

Recommendations:

_____

_____

_____

_____

_____

_____

_____

_____

Referred To: ☐center ☐*other center* ☐Outpatient w/

- ☐ STEPS Detox
- ☐ Council on Alcoholism & Drug Abuse
- ☐ Doctor's Hospital – ADU
- ☐ _____ Treatment Center
- ☐ Other :

_____

Counselor Signature and Credentials

GAMBLING TREATMENT REFERRAL PROGRAM

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I, the undersigned, do hereby authorize the ACG/Center of Recovery to release to the ____ JD District Attorney's Office, or the coordinator listed below, the dates and results of all scheduled treatment services/drug screens, and any absences from scheduled treatment appointments or scheduled drug screens. This disclosure shall be made specifically for the purpose of enabling the Gambling Treatment Referral Program Coordinator to evaluate my compliance with the conditions of my participation in the program. I am aware that the information described herein is protected under 42 CFR Part 2 and cannot be disclosed without written consent unless otherwise provided for in the regulation or law. I also understand that since this information is a condition of my participation in the Gambling Treatment Referral Program, I cannot revoke this consent until there has been a formal termination of such status.

I hereby release, hold harmless, and forever discharge the person or entity to whom this request/release is presented, and his or its agents and employees from any and all manner of actions, causes of action, and demands whatsoever, known or unknown, which I now have or may have, or claim to have against the person or entity to whom this request is presented or his or its agents or employees arising out of or by reason of complying with this request.

I understand that a formal termination of such status occurs if:

1. My participation in the Gambling Treatment Referral Program is revoked;

2. My Gambling Treatment Referral Program term has expired.

You must contact the Center of Recovery for an appointment within 72 hours. Failure to comply will result in a violation of your Gambling Treatment Referral Program Agreement.

DATE _____

PARTICIPANT _____

WITNESS _____

_____

COORDINATOR
GAMBLING TREATMENT REFERRAL PROGRAM
(___) _____

Use this area for treatment organization logo

Gambling Treatment Referral Program

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I, , authorize
(Client/Participant Name and SS#)

ACG/ *CORE*
(Name of person or agency making disclosure)

To disclose to: Diversion Coordinator, ____Judicial District, Office of the District Attorney, Gambling Treatment Referral Program

The following information: Client's name, demographics, assessment findings, diagnosis, treatment recommendations, treatment progress/compliance reports, referrals, lab work/screens, discharge summary, dates of services to client from the assigned program(s).

The purpose of this disclosure is:
To assess client and provide appropriate recommendations for treatment services/referrals to the Gambling Treatment Referral Program. To communicate between ACG staff and the referring District Attorney to best serve the needs of the client in the program.

I understand that my records are protected under the Federal Regulations governing the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR-2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that without my consent there is a prohibition against re-disclosure, and that in any event this consent expires automatically as follows:

Two years from date signed
(Specific date, event or condition upon which this consent will expire)

_____ _____
(Client's signature) (Date)

_____ _____
(Witness) (Date)

_____ _____
(Witness) (Date)

Attachment B Package

Gambling Treatment Referral Program Agreement

The District Attorney's Diversion Program Coordinator completes this form for the Participant to sign after he/she is referred and accepted to the program.

To complete this form:

Open the document and complete the first field (the area highlighted in gray). Press the tab key to go to the next field. The description of the field will appear on the bottom left of your computer screen.

State Gaming Control Board/Commission Request for Self-Exclusion form and instructions

To be completed by the Participant and given to State Police or other appropriate authority in the state

STATE OF LOUISIANA

VERSUS

GAMBLING TREATMENT REFERRAL PROGRAM AGREEMENT

The Office of the District Attorney, Judicial District agrees to divert prosecution of the above charge herein on condition that ("Participant") enters into this District Attorney's Gambling Treatment Referral Program Agreement ("Agreement") as follows:

1.

The Participant has to submit written monthly reports verifying his/her current address and phone numbers, including work and home, as applicable. The Participant must perform hours of community service with a non-profit organization and provide proof to this office.

2.

The Participant must pay an Administrative Fee of ($) DOLLARS in the form of a money order or cashier's check made payable to the 20th JDC District Attorney. **No cash or personal checks will be accepted. The Participant must also complete all requirements set forth by the _____ Association on Compulsive Gambling (ACG) and/or the Department of Health and Hospitals, Office for Addictive Disorders.**

3.

The Participant must not violate any state, federal, or local laws. The Participant waives prescription in this case. The Participant must sign the Gaming Control Board's Self-Exclusion form, banning himself/herself from all casino gaming establishments. The Participant must pay restitution in the form of a cashier's check or money order made payable to the victim(s) listed below:

Victim	**Amount Owed**	**Payment Plan** *Example: $/mo*

All restitution payments will be forwarded to the victim(s) through this office. Restitution must be made in full.

4.

The term of this Gambling Treatment Referral Agreement shall be . If the Participant successfully completes the terms and conditions of the Treatment Agreement, the District Attorney's Office agrees that no further action will be taken on the pending charge(s) listed in this Agreement.

I AGREE TO ALL OF THE ABOVE TERMS AND CONDITIONS, AND I UNDERSTAND THAT ANY VIOLATION OF THIS AGREEMENT WILL RESULT IN THE DISTRICT ATTORNEY'S OFFICE FILING FORMAL CRIMINAL CHARGES AGAINST ME FOR THIS OFFENSE.

DATE: _____

_____ _____

_____

_____, Investigator , Participant

Coordinator _____ JDC GTRP

P. O. Box ___

_____, LA _____

REQUEST FOR SELF-EXCLUSION FROM CASINO GAMING

SAMPLE

Louisiana Gaming Control Board

****

This form is to be completed by a patron requesting to be excluded from gaming activities in all Louisiana casino gaming establishments. All information contained on this form is confidential.

****

PLEASE PRINT OR TYPE THE ANSWERS TO THE FOLLOWING QUESTIONS IN THE SPACES PROVIDED

1. NAME: _____
LAST (INCLUDE SR., JR., ETC., IF APPLICABLE) FIRST MIDDLE

2. DO YOU USE ANY OTHER NAME OR NAMES? YES__ NO__ . IF YES, LIST THE ADDITIONAL NAME(S) BELOW (Include Maiden Name, Aliases, Nicknames or any other Names, Legal or Otherwise):

_____

3. HOME ADDRESS: _____
NUMBER AND STREET APT#

_____
CITY STATE ZIP CODE

4. HOME TELEPHONE NUMBER: _____
(AREA CODE) NUMBER

5. SOCIAL SECURITY NUMBER*: _____

*Disclosure of your Social Security number is voluntary. See instructions for further details.

6. DATE OF BIRTH: _____/_____/_____
MONTH DAY YEAR

7. HEIGHT: _____ 8. WEIGHT: _____
FT-IN LBS

PLEASE CHECK APPROPRIATE BOX:

9. GENDER:
- ☐ (M) MALE
- ☐ (F) FEMALE

10. HAIR COLOR:
- ☐ (BK) BLACK
- ☐ (BR) BROWN
- ☐ (BD) BLOND
- ☐ (RD) RED
- ☐ (GY) GRAY
- ☐ (WH) WHITE
- ☐ (BA) BALD
- ☐ (OT) OTHER _____

11. EYE COLOR:
- ☐ (BK) BLACK
- ☐ (BR) BROWN
- ☐ (HZ) HAZE
- ☐ (BL) BLUE
- ☐ (GY) GRAY
- ☐ (GR) GREEN
- ☐ (OT) OTHER____

12. OTHER DISTINGUISHING PHYSICAL CHARACTERISTICS (i.e. scars, tattoos, distinguishing marks, etc.):

_____

WAIVER AND RELEASE

I hereby release, forever discharge, indemnify, and hold harmless the State of Louisiana, the Louisiana Gaming Control Board ("Board"), the Louisiana Department of Public Safety and Corrections, Office of State Police ("State Police"), the Department of Justice, Office of the Attorney General ("Attorney General's Office") and their members, agents, and employees, from any liability to me and my heirs, administrators, executors and assigns for any loss, injury, or harm, monetary or otherwise, which may arise out of or by reason of any act or omission relating to this request for self-exclusion, my request for removal from the self-exclusion list or my removal from the self-exclusion list including, but not limited to (1) its processing or enforcement, (2) the failure of a casino gaming licensee to withhold gaming privileges from, or restore gaming privileges to me, (3) permitting me to engage in gaming activity at a licensed casino gaming establishment while on the list of self-excluded persons, and (4) disclosure of the information contained in the self-exclusion request or list, except for a willfully unlawful disclosure of such information.

ACKNOWLEDGEMENT

I understand and read the English language or have had an interpreter read and explain this form. I am voluntarily requesting exclusion from all gaming activities at all Louisiana casino gaming establishments because I am a compulsive and/or problem gambler. I certify that the information that I have provided above is true and accurate, and that I have read, understand, and agree to the waiver and release included with this request for self-exclusion. I am aware that my signature below authorizes the Board or the State Police to direct all Louisiana casino gaming licensees, including the Casino Operator and Casino Manager, to restrict my gaming activities and access to casino gaming establishments for a minimum period of five (5) years from the date I receive written notice of self-exclusion from the Board. During such period of time, I will not attempt to enter the designated gaming area of any casino gaming establishment. I further understand that my name will remain on the self-exclusion list until 1) I submit a written request to the board to terminate my self-exclusion; 2) a hearing is held; and 3) there is a written decision of the Board determining that there is no longer a basis for me to be maintained on the list. I am aware that I cannot request removal from the list before five (5) years have elapsed from the date I receive written notice of self-exclusion from the Board. I am aware and agree that during any period of self-exclusion, I shall not collect in any manner or proceeding any winnings or recover any losses resulting from any gaming activity at any casino gaming establishment and that any money or thing of value obtained by me from, or owed to me by, the Casino Operator, Casino Manager, or a casino gaming licensee as a result of wagers made by me while on the self-exclusion list shall be withheld and remitted to the state of Louisiana.

SIGNED: _____ DATE: _____

==========DO NOT WRITE BELOW - FOR BOARD/ STATE POLICE PERSONNEL USE ONLY

TYPE OF I.D. OFFERED: _____

I certify that the signature of the person requesting suspension of gaming privileges appears to agree with that contained on the above identification credentials, and any physical description or photograph of the person appears to agree with his or her actual appearance.

_____ Date: _____

BOARD/STATE POLICE Member, Agent, or Employee

Forwarded to casino gaming establishments:

Date: _____ _____

BOARD/STATE POLICE Member, Agent, or Employee

INSTRUCTIONS

1. Please read these Instructions and the Request for Self-exclusion (the "Request Form"), including the waiver and acknowledgement, carefully. By signing and submitting the Request Form, you are acknowledging that you are a compulsive and/or problem gambler and agreeing to be excluded from casino gaming activities at all casino gaming establishments regulated by the Louisiana Gaming Control Board ("Board"). Casino gaming establishments regulated by the Board include all licensed riverboat casinos, all pari-mutuel live racing facility casinos, and the official gaming establishment (landbased casino) in New Orleans, Louisiana. This means you cannot engage in gaming, receive or use complimentary goods or services, be a member of a slot or players club, receive credit from any casino, cash checks at a casino, collect winnings or any other thing of value or recover losses. Also, the casinos are to remove your name from their direct marketing lists.

2. The completed Request Form must be submitted in person by the person requesting self-exclusion at one of the following Department of Public Safety, Office of State Police ("State Police") locations during normal business hours:

   Casino Gaming Division
   5615 Corporate Boulevard
   Baton Rouge, Louisiana 70806
   (225) 925-4801

   Casino Gaming Division
   2121 Airline Highway,
   Suite 300
   Metairie, Louisiana 70001
   (504) 838-5660

   Casino Gaming Division
   Lake Charles Field Office
   750 Bayou Pines East
   Lake Charles, Louisiana 70601
   (337) 491-2850

   Casino Gaming Division
   Shreveport Field Office
   3010 Knight St., Ste. 270
   Shreveport, Louisiana 71105
   (318) 862-9730

3. You must present valid identification such as a driver's license, passport, or military identification card. Your photograph will be taken by State Police personnel.

4. Your photograph and identifying information will be distributed to appropriate personnel of the Casino Operator, Casino Manager, and all casino gaming licensees. The information contained in the self-exclusion requests and the self-exclusion list maintained by the Board is not open to public inspection and every effort will be made to maintain its confidentiality. However, neither the Board, State Police, nor the Louisiana Department of Justice, Office of the Attorney General ("Attorney General's Office") are liable for any disclosures of such information other than a willfully unlawful disclosure. Further, Louisiana the Casino Operator, Casino Manager and all casino gaming licensees may alert other Louisiana casino gaming establishments to be on the look out for you if you are discovered attempting to engage in gaming activities while on the self-exclusion list.

5. In accordance with Section 5 of the Privacy Act, 7 U.S.C. 522a, disclosure of your social security number ("SSN") to the Board is voluntary. Failure to provide your SSN is not grounds for denial of your request for self-exclusion. The request for your SSN is made pursuant to the

Louisiana Gaming Control Law, *La. R.S. 27:1, et seq.* (Specifically *La. R.S. 27:27.1(D).* If provided, your SSN will be disclosed to Louisiana casino gaming licensees, including the Casino Operator and Casino Manager, for their use in identifying you as a self-excluded person in order to deny you credit, check cashing and similar privileges, and for purposes of withholding money or things of value obtained by you or owed to you as a result of wagers made by you while on the self-exclusion list.

6. Your name will remain on the self-exclusion list and you will be excluded from casino gaming activities at all casino gaming establishments regulated by the Board for a minimum of **five (5) years**. After the expiration of five years from the date you received written notice of self-exclusion from the Board, your name will remain on the self-exclusion list. Your name will not be removed unless 1) you request that it be removed; 2) a hearing is held; and 3) there is a final decision of the Board determining that there is no longer a basis for you to be maintained on the self-exclusion list; however, you cannot request removal from the list before five (5) years have elapsed from the date you received written notice of self-exclusion from the Board.

7. **It is your responsibility to refrain from gaming activities.** Neither the Board, State Police, nor the Attorney General's Office are liable for any acts or omissions in processing or enforcement of your request for self-exclusion, including failure to withhold your gaming privileges. However, if you are caught gambling at a casino, any winnings, including any chips, tokens, or electronic gaming device credits in your possession will be withheld and remitted to the State of Louisiana, you will be escorted from the gaming floor, and may be subject to arrest pursuant to the Gaming Control Law or any other applicable provisions of law. Further, neither the Board, State Police, nor the Attorney General's Office are liable for any acts or omissions in processing or enforcement of any later request by you to be removed from the self-exclusion list or your removal from the self-exclusion list.

8. For the statutes and rules governing self-exclusion, see the Louisiana Gaming Control Law at La. R.S. 27:27.1(D) and the regulations set forth at LAC 42:III.304.

Attachment C Package

Gambling Treatment Referral Program Weekly Progress Report

To be completed by ACG personnel and sent to the Diversion Program Coordinator

Gambling Treatment Referral Program Monthly Diversion Report

To be completed by the Participant and mailed to the District Attorney's Diversion Program Coordinator

Community Service Program Completion Report

To be completed by the Participant and signed by the not for profit

Treatment organization logo

Gambling Treatment Referral Program Pilot Project
Weekly Report to District Attorney's office

(PLEASE PRINT)

Report Date:		DA Program Coordinator:	
Participant:		S.S. #	
D.O.B.		Docket #	
Participant has attended of sessions since last report.			
UDS: Results			
Employment/School Status:			
Medical Concerns:			
Family Participation:			

Attitude Towards Treatment/Recovery:
☐Excellent ☐Good ☐ Fair ☐ Needs Improvement ☐ Poor

Motivation for Treatment/Recovery:
☐Excellent ☐Good ☐ Fair ☐ Needs Improvement ☐ Poor

Level of Participation:
☐Excellent ☐Good ☐ Fair ☐ Needs Improvement ☐ Poor

Homework Assignments:
☐Excellent ☐Good ☐ Fair ☐ Needs Improvement ☐ Poor

GA attendance meetings attended since last report

AA attendance : meetings attended since last report

Comments/Recommendations:

Court Actions:
Counselor Assigned to case:

GAMBLING TREATMENT REFERRAL PROGRAM
MONTHLY REPORT

Name _____ *Phone* _____
Address _____
Change of Address? ☐ Yes ☐ No
Employer _____ *Phone* _____
Address _____
Position _____ *Full-time* ☐ *Part-time* ☐
Do you own a vehicle? _____ *Year* _____ *Make* _____
Color _____ *License #* _____
Have you been arrested or received any tickets since your last report?
☐ *Yes* ☐ *No* *If yes, explain:*

_____

_____

If we should need to reach you, who would know your whereabouts?
Name _____ *Phone* _____
Adults living in your home: *Relationship*

_____

_____

_____

_____

I have truthfully answered all the information on this form and have not withheld any information from the Program Coordinator.

_____
Your signature

**Program fee included?* ☐ *Yes* ☐ *No* *Amount?* _____
Restitution included? ☐ *Yes* ☐ *No* *Amount?* _____

**Make all money orders payable to:*
_____ *District Attorney*

Mail the completed form by the 15th of each month to:
_____, *Diversion Coordinator*
P.O. Box
, state

For any additional comments, use back of this sheet

DISTRICT ATTORNEY
20th Judicial District

COMMUNITY SERVICE PROGRAM COMPLETION REPORT

This request is being made as a condition of: The _____Gambling Treatment Referral Program

I, _____ request _____
Participant Non-profit organization

to allow me to perform my community service with this non-profit organization. I agree to indemnify and hold the provider, its agents and employees, and the Office of the _____ District Attorney and its agents and employees harmless in the event of an accident or injury of any type, including any claim for worker's compensation. This community service is to be performed without any payment or reimbursement in any form to participant from the provider or any third person.

THE ABOVE REFERENCED INDIVIDUAL HAS BEEN ORDERED BY THE _____ DISTRICT ATTORNEY'S OFFICE TO COMPLETE _____ HOURS OF COMMUNITY SERVICE.

DATE	HOURS WORKED	WORK PERFORMED	SUPERVISOR

Participant

THIS FORM MUST BE RETURNED TO THE _____ DISTRICT ATTORNEY'S GAMBLING TREATMENT REFERRAL PROGRAM COORDINATOR BY THE PARTICIPANT. ALL WORK MUST BE PERFORMED THROUGH A NON-PROFIT ORGANIZATION. FALSIFICATION OF THIS FORM IS A VIOLATION OF THE LAW.

Mail to:
, Diversion Coordinator
P.O. Box
, state