

**DRUG COURT PROGRAM APPLICATION**

*Please check the appropriate box to indicate which Drug Court Program applies to you.*

**Adult Felony Post Plea Drug Court**  
First time offenders (Do not check this box if you have more than one felony charge).

**Post-Adjudatory Drug Court Expansion**  
Prison bound offenders with sentencing scores of 60 points or less.

**PERSONAL INFORMATION**

First Name: \_\_\_\_\_ Middle: \_\_\_\_\_ Last Name: \_\_\_\_\_ Suffix: \_\_\_\_\_

Alias: \_\_\_\_\_

Social Security # (last four): \_\_\_\_\_ DL State: \_\_\_\_\_ DL/ID #: \_\_\_\_\_ DL Status: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Living Arrangement:  Independent  Homeless  Dependent with (Name and Relationship)

Phone Number: \_\_\_\_\_ Alternate Number: \_\_\_\_\_ Alternate Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Marital Status:  Single  Married  Separated  Divorced  Widowed

Spouse's Name: \_\_\_\_\_ Spouse's Occupation: \_\_\_\_\_

Race/Ethnicity:  African American  Caucasian  Multi-Racial  Asian / Pacific Islander  
 Hispanic / Latino  Native American  Other: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone(s): \_\_\_\_\_

**NAMES OF CHILDREN**

Check this box if you do not have any children

Children (use back page if there are more):

Name: \_\_\_\_\_ Living with Client:  Yes  No/Lives with: \_\_\_\_\_

Attending School:  Yes  No School Attending: \_\_\_\_\_

Male  Female  DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Name: \_\_\_\_\_ Living with Client:  Yes  No/Lives with: \_\_\_\_\_

Attending School:  Yes  No School Attending: \_\_\_\_\_

Male  Female  DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Name: \_\_\_\_\_ Living with Client:  Yes  No/Lives with: \_\_\_\_\_

Attending School:  Yes  No School Attending: \_\_\_\_\_

Male  Female  DOB: \_\_\_\_\_ Age: \_\_\_\_\_

**Child Support:**

N/A  Paying Current  Paying Not Current  Not Paying  Support Enforcement Involved:  Yes  No

List others residing in the home other than children or spouse:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Office of the Court Administrator, Fifth Judicial Circuit  
 Marion County Drug Court  
 110 NW 1<sup>st</sup> Avenue, Room 1-1027  
 Ocala, Florida 34475  
 (352) 401-7808

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**CRIMINAL HISTORY**

Name of Judge currently assigned to the criminal case: \_\_\_\_\_

Date of Arrest	CURRENT CHARGES (list all):	Court Case #(s):

Do you have any pending charges in another county? Yes  No  If yes, name of county \_\_\_\_\_

Charges \_\_\_\_\_

Date of Arrest	CRIMINAL HISTORY List charges	City/State

Current Charge or Previous Conviction of a Violent Crime or Sex Offense, Other Than Domestic Violence?  Yes  No

If Yes: What Offense \_\_\_\_\_

Previous Conviction for Domestic Violence?  Yes  No Outstanding Warrants:  Yes  No

Pending Criminal Charges:  Yes  No Previous Court Failures to Appear:  Yes  No

Currently on Probation:  Yes  No Qualifying Sentencing Score: \_\_\_\_\_

History of Prior Drug Court Participation:  None  Successful  Voluntary Withdrawal  Unsuccessful  Absconded

Clerk Case Number: \_\_\_\_\_ FDOC#: \_\_\_\_\_

Probation Officer's Name: \_\_\_\_\_

Prior Adjudications:  Yes  No

Counts: \_\_\_\_\_

Current Dependency Case?  Yes  No

Has there ever been a Dependency Case?  Yes  No

Jail Status:  Jail  Not In Jail

Family Care Manager Name (if applicable): \_\_\_\_\_

Jail Admit Date: \_\_\_\_\_

Date Released From Jail: \_\_\_\_\_

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**EMPLOYMENT HISTORY**

Current Employment Status:  Unemployed  Full-Time  Part-Time  Disabled  Retired  Student

**If Employed:**

Name of current employer: \_\_\_\_\_

Average number of hours worked per week: \_\_\_\_\_

Length of time with current employer: \_\_\_\_\_ Months \_\_\_\_\_ Years

Primary Source of Support:

<input type="checkbox"/> Adoption Subsidy	<input type="checkbox"/> Disability	<input type="checkbox"/> Family
<input type="checkbox"/> Foster Care Subsidy	<input type="checkbox"/> Retirement Plan	<input type="checkbox"/> Salary/Wages
<input type="checkbox"/> Social Security	<input type="checkbox"/> Social Security Disability	<input type="checkbox"/> Veteran's Benefits
<input type="checkbox"/> SNAP/AFDC	<input type="checkbox"/> Workers Compensation	<input type="checkbox"/> None
<input type="checkbox"/> Other: _____	Gross Monthly Income (from all sources): \$ _____	

Employment History (previous job experiences and why you are no longer employed there):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What type of work are you interested in?

\_\_\_\_\_  
\_\_\_\_\_

Describe any previous volunteer involvement you have had:

\_\_\_\_\_  
\_\_\_\_\_

Describe any community or church involvement you have been a part of:

\_\_\_\_\_  
\_\_\_\_\_

**Transportation Status:**

Reliable Transportation  No Reliable Transportation Comments: \_\_\_\_\_  
Make/Model of Vehicle (s) \_\_\_\_\_ Vehicle is:  Owned  Leased

Prior Military Service (Years in Service, Branch & Rank): \_\_\_\_\_

Do you have a DD214?  Yes  No Discharge Status: \_\_\_\_\_ Registered with VA Services:  Yes  No

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**EDUCATION HISTORY:**

Highest Education Completed:

- \_\_\_ No High School Diploma: Last Grade Completed: \_\_\_\_\_      \_\_\_ GED      \_\_\_ High School Diploma  
\_\_\_ Some Trade School      \_\_\_ Trade School Graduate      \_\_\_ Major/Minor: \_\_\_\_\_  
\_\_\_ Some College      \_\_\_ College Graduate 2 year Program      \_\_\_ Major/Minor: \_\_\_\_\_  
\_\_\_ College Graduate 4 year Program      \_\_\_ Major/Minor: \_\_\_\_\_  
\_\_\_ Advanced Degree      \_\_\_ Major/Minor: \_\_\_\_\_  
\_\_\_ Currently Attending School      Name of School Attending: \_\_\_\_\_

If you do not have your High School Diploma or GED, explain what led you to drop out : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Did you have an Individualized Educational Program (“IEP”) when in school?  Yes  No  Unsure

Were additional services provided while you were in school (tutoring, specialized classes, counseling, speech or other therapies)?  
\_\_\_\_\_

What difficulties/issues did you have in school?  
\_\_\_\_\_  
\_\_\_\_\_

**HOME LIFE**

Number Of Times Moved In The Last Three Years? \_\_\_ Comments: \_\_\_\_\_  
Length of Time at Current Primary Address? \_\_\_ Comments: \_\_\_\_\_

**Trauma/Loss**

Has there been any significant trauma or loss in your life (e.g., loss of a family member or friend, separation from a close relative)?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Your turn to share...anything else you feel is important for us to know:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**RELEASE OF INFORMATION**

The purpose of, and need for, this exchange of information is to provide information about my eligibility for, and participation in the Marion County Drug Court Programs' application process. The information to be exchanged may include information about any diagnosis which will include, but is not limited to: medical history, including current assessments, diagnosis, treatment and medications, arrest and prior criminal record, risk and alcohol/drug use assessment and diagnosis information.

The Marion County Drug Court Program team members are: the presiding Drug Court Judge, Assistant State Attorney, Assistant Public Defender, or other Defense Counsel, Director of Case Management; Drug Court Manager, Drug Court staff, Court Administration, the Marion County probation provider, and treatment providers and other professionals as deemed necessary.

I agree that the disclosure of the Application, Intake/Screening and Treatment information, prior to the Drug Court termination, sentencing, and /or revocation of this consent shall not be a breach of my right to confidentiality.

I understand that any disclosure made regarding mental health and substance abuse treatment is bound by Part 2 of Title 42 of the Code of Federal Regulations (42CFR, part 2), which governs the confidentiality of mental health and substance abuse patient records and that recipients of this information may re-disclose it only in connection with their official duties, and only with respect to these particular criminal proceedings.

\_\_\_\_\_  
Signature of applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of attorney (Please Print)

\_\_\_\_\_  
Signature of attorney

\_\_\_\_\_  
Date

*The Marion County Drug Court Programs do not discriminate against qualified applicant on the basis of race, color, religion, gender, age, national origin, marital status, handicap (disability) or veteran status or as otherwise prohibited by federal, state or local law.*

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### Intake Screening Information

**SUBSTANCE ABUSE HISTORY**

*Drug of Choice: Enter P-Primary Drug of Choice, S-Second Drug of Choice, T-Any substances you have used in your lifetime.*

<b>P-S-T</b>	<b>Substance</b>	<b>Age of first Use</b>	<b>Date of last Use</b>	<b>Ever Injected?</b>
	Alcohol			<input type="checkbox"/> Yes <input type="checkbox"/> No
	Marijuana- Cannabinoids			<input type="checkbox"/> Yes <input type="checkbox"/> No
	Cocaine			<input type="checkbox"/> Yes <input type="checkbox"/> No
	Crack			<input type="checkbox"/> Yes <input type="checkbox"/> No
	Methamphetamine			<input type="checkbox"/> Yes <input type="checkbox"/> No
	Methadone			<input type="checkbox"/> Yes <input type="checkbox"/> No
	Steroids/Inhalants			<input type="checkbox"/> Yes <input type="checkbox"/> No
	Ketamine (Special K)/PCP/DXM			<input type="checkbox"/> Yes <input type="checkbox"/> No
	Salvia			<input type="checkbox"/> Yes <input type="checkbox"/> No
	"Spice"-Synthetic Marijuana			<input type="checkbox"/> Yes <input type="checkbox"/> No
	"Bath Salts"			<input type="checkbox"/> Yes <input type="checkbox"/> No
	MDPV "Molly's"			<input type="checkbox"/> Yes <input type="checkbox"/> No
	LSD/Mescaline/Psilocybin (Mushrooms)			<input type="checkbox"/> Yes <input type="checkbox"/> No
	MDMA (Ecstasy)/Rohypnol/GHB			<input type="checkbox"/> Yes <input type="checkbox"/> No
	RX: Stimulants - Adderall- Ritalin etc.			<input type="checkbox"/> Yes <input type="checkbox"/> No
	RX: Depressants - Xanax-Quaalude etc.			<input type="checkbox"/> Yes <input type="checkbox"/> No
	RX: Opioids - Oxy/Roxy/Lortab etc.			<input type="checkbox"/> Yes <input type="checkbox"/> No
	Other(s): _____			<input type="checkbox"/> Yes <input type="checkbox"/> No

Are you a current Tobacco Smoker?  Yes  No      How much tobacco do you smoke per day? \_\_\_\_\_  
 Are you interested in information about the Smoking Cessation Program?  Yes  No

**History of Substance Abuse Treatment:**

\_\_\_\_\_ Never had any S.A. Treatment  
 \_\_\_\_\_ Court Ordered S.A. Treatment    Year: \_\_\_\_\_ Location: \_\_\_\_\_ Outcome: Completed/Did not Complete  
 \_\_\_\_\_ Other S.A. Treatment Attended    Year: \_\_\_\_\_ Location: \_\_\_\_\_ Outcome: Completed/Did not Complete  
 \_\_\_\_\_ Year: \_\_\_\_\_ Location: \_\_\_\_\_ Outcome: Completed/Did not Complete

Were you under the influence of any substances when arrested for this charge or any other charges?  Yes  No  
 If yes, explain: \_\_\_\_\_

**HEALTH HISTORY**

Current Medications:  Yes  No      If Yes, Condition is:  Physical  Psychological  Both  
 Medications: \_\_\_\_\_

Ever been treated for substance abuse through a pharmacological intervention such as Methadone Treatment?  Yes  No  
 Where? Comments: \_\_\_\_\_

Pregnant?:  Yes  No  N/A    Due Date: \_\_\_\_\_ Hospital: \_\_\_\_\_ Doctor: \_\_\_\_\_  
 Comments: \_\_\_\_\_

Medical Insurance:  None  Medicaid  Medicare  Private: Carrier: \_\_\_\_\_  
 History of Mental Health Condition(s):  Yes  No      Explain: \_\_\_\_\_

History of Medical Condition(s):  Yes  No      Explain: \_\_\_\_\_  
 History of Communicable Disease:  Hep B  Hep C  HIV  Tuberculosis

