Office of the Court Administrator, Fifth Judicial Circuit
Marion County Drug Court
110 NW 1st Avenue, Room 1-1027, Ocala, Florida 34475
(352) 401-6729

DRUG COURT PROGRAM APPLICATION

***IMPORTANT:* APPLICATIONS WILL BE REVIEWED BY DRUG COURT STAFF & THE OFFICE OF THE STATE ATTORNEY.**

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

PERSONAL INFORMATION

Male ☐ Female ☐

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: _____

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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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 Current Dependency Case? ☐ Yes ☐No

Counts: _____ 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:

____ Adoption Subsidy	____ Disability	____ Family
____ Foster Care Subsidy	____ Retirement Plan	____ Salary/Wages
____ Social Security	____ Social Security Disability	___ Veteran's Benefits
____ SNAP/AFDC	____ Workers Compensation	____ None
____ 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: _____

Do you have any close friends? Who? Are they involved with the court system?
_____
_____
_____
_____

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, Public Defender, or other Defense Counsel, Director of Case Management; Drug Court Manager, Drug Court staff, the Marion County probation provider and treatment providers as needed.

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

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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.***

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

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