MARION COUNTY VETERAN TREATMENT COURT APPLICATION

PLEASE PRINT

Date:_________________________ VTC Case #___________________

Last Name: ________________________________ First Name:___________________________________ MI: __________

Sex (M/F): _____________ Date of Birth: ______________________________ Race: _______________________________

Address: ____City:_______________State: ____________ZIP:___________

Mailing Address if different:____

Telephone: Home: ____________________________Work: ______________________Cell: __________________________

Driver's license or state ID card: (Circle one) Yes / No DL or ID Card Number: _______________________________

Social Security Number: _______________________________

Dates of Military Service:______________________________ Dates of Combat Service(if any):_______________________

Possession of DD-214: ______yes ______no Branch of Service: ____

Type of Discharge:______________________________ Reason for Discharge: _______________________________________

____

____

Diagnosis of a service-related mental illness: _________PTSD _________TBI _________Substance Abuse
Service Connected Disability: ___Yes ___No Disability Rating, if any:_______

NOTE: THE ANSWERS YOU GIVE IN THE FOLLOWING SECTION WILL NOT BE CONSIDERED AN ADMISSION OF GUILT AND WILL NOT BE USED AGAINST YOU IN A COURT OF LAW

SUBSTANCE ABUSE HISTORY

Prior Substance Abuse: Yes No Prior Substance Abuse Treatment: Yes No
IV Drug User: Yes No History of IV Drug Use: Yes No

Drug of Choice: Enter "P" for Primary, "S" for Secondary, "A" for Additional, "T" for Tried.

___Tobacco ___Alcohol ___Marijuana ___Steroids/Inhalants
___Cocaine ___Crack ___Amphetamine ___Methamphetamine
___RX: Depressants ___RX: Stimulants ___RX: Pain Killers ___Other:___________________

___Dissociative: Ketamine/PCP/Salvia/DXM/Spice/Bath Salts ___ Club Drugs: MDMA/Rohypnol/GHB
___Hallucinogens: LSD/Mescaline/Psilocybin

Age Began Using Drugs:______ Years Using Drugs:______ Age Began Alcohol:____ Years Using Alcohol:____

Were you under the influence of any substances when arrested for this charge? ___Yes ___No

Explain:____

Have you ever participated in a substance abuse treatment program? ____Yes ____No

If Yes, Where and When:____

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Currently Prescribed 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:____

How long have you lived in Marion County?: ____

Why do you believe Veterans Treatment Court would be appropriate for you? ______________________________

____

Emergency Contact Name:____

Telephone#(s):_______________________________________Relationship:________________________________

Address:____

Current Charge(s): ____

Currently in jail (Please Circle one): Yes / No If so, date of incarceration: ______________________________

Previous Convictions:____

____

____

Circle One: Public Defender / Private Attorney Attorney's Name: ____________________________

Firm Name (if applicable): _____________________ Phone Number for Attorney:____________________

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MARION COUNTY VETERAN TREATMENT COURT APPLICATION

The purpose of, and need for, this exchange of information is to provide information about my eligibility for, and participation in, Veteran Treatment Court's application process. The information to be exchanged may include information about my 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 Veteran Treatment Court Treatment team members are; the presiding Veteran Treatment Court Judge, Assistant State Attorney, Public Defender, or other Defense Counsel, Veteran Treatment Court Coordinator, Court Alternatives Supervisor/staff, NAMI representative, Veteran Justice Officer (VJO) and Law Enforcement in their capacity as a Veteran Treatment Court team member.

I agree that the disclosure of the above information, prior to Veteran Treatment 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

Please return the completed referral along with the Consent for Disclosure to:
The Clerk of the Court, County Criminal, Room 101

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MARION COUNTY VETERAN TREATMENT COURT

CASE NUMBER: ____________________

CONSENT FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

I, ____, hereby give my permission
(Name of Defendant)
for an ongoing exchange of information among _________________________________
(Treatment Provider)
and the following individuals and agencies working together in the Marion County Veteran Treatment Court

- Veteran Treatment Court Presiding Judge
- Office of the State Attorney
- Public Defender / other Defense Counsel
- Veteran Treatment Court Coordinator/staff
- Court Administration, in their capacity as a veteran treatment court team member
- Sheriff's Office, in their capacity as a veteran treatment court team member
- Probation Staff
- NAMI representative, in their capacity as a veteran treatment court team member
- Other service agencies who are providing services and treatment to participants of this court
- My victim(s), to the extent my information is in the pre-sentence investigation report

and also____
Name of Person, Relationship

The purpose of, and need for, this exchange of information is to provide information about my eligibility for and participation in the Marion County Veteran Treatment Court, about the treatment I need, and about my progress. The information to be exchanged may include information about my diagnosis, treatment plan, treatment attendance, program compliance, progress, and prognosis related to each Veteran Treatment Court phase of participation. This information will allow the Team to plan and coordinate the services I need, to impose appropriate sanctions or incentives for my behavior, to submit billings for my services, to maintain data about me, and to audit, evaluate, or conduct research about Veteran Treatment Court activities and effectiveness. It will also allow any persons named in this consent (such as family members) to be involved in my Veteran Treatment Court activities. I further understand that some or all of this information will be discussed in open court. The nature of the information to be shared 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, treatment plans, court directives, drug test

results, progress reports, reports of program compliance and other related behavior, and recommendations for services, sanctions, and incentives.

Disclosure of this otherwise confidential information may be made only as necessary for, and pertinent to, hearings, case planning, treatment and/or reports concerning the above referenced Case Number. No person, other than as listed above, will have access to this information without my further consent.

I understand that this consent will remain in effect until there has been a formal and effective termination of my involvement with the Veteran Treatment Court for the above referenced case, EITHER by my successful completion of the Veteran Treatment Court requirements OR upon sentencing for my original offense, if I am terminated from Veteran Treatment Court, OR upon written revocation. I understand that revoking this consent will result in my termination from Veteran Treatment Court. I agree that the disclosure of the above information, prior to Veteran Treatment Court termination, sentencing, and/or revocation of this consent shall not be a breach of my right to confidentiality. I further understand that individuals and agencies working together in the Marion Veteran Treatment Court will file Veteran Treatment Court forms in my underlying misdemeanor court file and that the forms will be open to public inspection."

I understand that any disclosure made regarding substance abuse and mental health treatment is bound by Title 42 of the Code of Federal Regulations (42CFR) which governs the confidentiality of substance abuse and mental health 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.

__________________ ____________________________________

Date Defendant’s Signature

____

Printed Name

Notice to Receiving Person or Organization: Prohibiting Re-disclosure w/o Consent

This notice accompanies a disclosure of information concerning a client in alcohol/drug abuse and mental health treatment made to you with the consent of such client. This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

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