ERIE COUNTY TREATMENT COURT – APPLICATION

Application must be completed in its entirety. Incomplete applications will be returned to the attorney of record and may delay the review/admissions process.

LEGAL REPRESENTATION	
Attorney Name:	Phone:
Address:	Email:
☐ Public Defender ☐ Private/Court Appointed	☐ Application completed by Attorney (if applicable)

CRIMINAL/CHARGE INFORMATION -- TO BE COMPLETED BY DEFENSE ATTORNEY			
PLEASE LIST ALL DOCKET NUMBERS FOR WHICH YOUR CLIENT IS APPLYING FOR TREATMENT COURT:			
Do any of the cases include use or possession of a weapon? ☐ Yes ☐ No			

APPLICANT INFORMATION				
Name: *First* *Middle* *Last*			Alias/Maiden:	
Physical Address:		*City*	*State*	*Zip Code*
Mailing Address: *Same as Above* ☐		*City*	*State*	*Zip Code*
County of Residence:		Currently Incarcerated: ☐ Yes ☐ No		
		Currently on Prob/Parole: ☐ Yes ☐ No		
		If yes, where? Officer?		
Home Phone:	Cell:		Other:	
Email:		Primary language spoken:		
Date of Birth:		Social Security Number:		
Race: ☐ Asian/Pacific Islander ☐ Bi-Racial ☐ Black ☐ White ☐ Native ☐ Unknown/Unreported				
Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐Unknown/Unreported		How do you identify yourself?		
Height:	Hair Color:	Do you have reliable transportation? ☐ Yes ☐ No		
Weight:	Eye Color:	Primary source of Transportation:		
Do you have a license or ID? ☐ Yes ☐ No	If yes, status: ☐ Valid ☐ Suspended ☐ Expired	License/ID #:		
		State Issued:		
If revoked/suspended, are you able to regain your driver's license? ☐ Yes ☐ No				
Prior participation in a Treatment Court? ☐ No ☐ Yes, specify county:				

SUBSTANCE ABUSE HISTORY

Have you ever abused drugs or alcohol? ☐ Yes ☐ No	Currently abusing? ☐ Yes ☐ No

If no to either of the above, move on to the next section. If yes to either of the above, please complete the following:

Drug(s) of Choice:	*1st*	*2nd*	*3rd*
Frequency of use:			
Date of last use:			
Amount used:			

Have you ever received any level of treatment for substance abuse disorder? ☐ Yes ☐ No

Are you currently in any level of treatment? ☐ Yes ☐ No

If yes to the above, explain (inpatient/outpatient, date, location, current/successful/unsuccessful):

Age first used drugs:	Age first used alcohol:	History of IV Use? ☐ Yes ☐ No

Are you **currently** prescribed pharmacological interventions (MATs) for substance abuse?	☐ Yes ☐ No	If yes, list medication(s): *(e.g. Methadone, Vivitrol, Suboxone)*
		Where do you receive this medication from?:

MENTAL HEALTH HISTORY

Prior psychiatric mental health inpatient/outpatient treatment? ☐ Yes ☐ No	Currently in M/H treatment? ☐ Yes ☐ No

If yes to the questions above, was the mental health diagnosis connected to military service? ☐ Yes ☐ No

What is the name of your current MH/SC case manager (if applicable):

Have you been diagnosed by a medical professional with a mental health disorder? ☐ No ☐ Yes, when?

If yes, who diagnosed you?	Disorder(s) diagnosed?
Are you prescribed any mental health medications? ☐ No ☐ Yes	If yes, list medications:

PHYSICAL HEALTH HISTORY

Medical Insurance:	☐ County Insurance	☐ Private Insurance; specify:
	☐ Medicaid/Medicare	☐ Other/none

If female, are you pregnant? ☐ No ☐ Yes – Due Date:

List any past or present medical conditions:

List any medications you are taking:

EDUCATION, EMPLOYMENT, AND HOUSING STATUS

High level of Education **completed** (select one):

☐ Any grade up to 11th ☐ GED ☐ High School Diploma ☐ Some Trade School

☐ Trade School Graduate ☐ Some College ☐ College Graduate (2 yr) ☐ College Graduate (4 yr)

☐ Some Post-Graduate ☐ Advanced Degree

☐ Current Student School: ☐ Full-Time ☐ Part-Time

Employment Status (select one):

☐ Unemployed ☐ Employed Full-Time (35+ hours/week) ☐ Volunteer

☐ Retired ☐ Employed Part-Time (<35 hours/week) ☐ Disabled

Employer: Address:

Start Date: Occupation:

Primary Source of Support (select all that apply):

☐ Adoption Subsidy ☐ SSI ☐ SSD ☐ Welfare ☐ None

☐ Foster Care Subsidy ☐ Retirement Plan ☐ Workers Comp ☐ Family ☐ Other

☐ Unemployment ☐ Veterans Benefits ☐ Salary/Wages ☐ Disability

Housing Status: ☐ Independent ☐ Dependent *(incarcerated, with friends, etc.)* ☐ Homeless

FAMILY/CHILDREN INFORMATION

Marital Status: ☐ Single ☐ Separated ☐ Widowed ☐ Married ☐ Divorced ☐ Living Together

Name of Paramour/Partner/Spouse:

# of Children:	# of Dependent Children:	Custody of all minor children: ☐ Yes ☐ No ☐ N/A

Visitation rights for children not residing with you? ☐ Yes ☐ No ☐ N/A

Currently have contact with your primary family? ☐ Yes ☐ No ☐ N/A

Child support amount (if applicable): $ per month

MILITARY HISTORY

Have you (defendant) ever been in the military? ☐ Yes ☐ No *If yes, please answer the questions below.*

Branch:	Enlistment Date:	Years of Service:

☐ Still serving ☐ Dishonorable ☐ Clemency ☐ Other than honorable ☐ General (includes medical)

☐ Honorable ☐ Bad Conduct ☐ Dismissal ☐ Entry level separation

Discharge Date:	Rank at Discharge:
Deployed abroad: ☐ Yes ☐ No	If yes, specify where:
Military combat: ☐ Yes ☐ No	If yes, specify the number of combat zones:

Conflict Era of Service: (Select all that apply) ☐ Korea ☐ Vietnam ☐ ODS (Iraq/Kuwait 1990-2003) ☐ OEF (Afghanistan 2001-present) ☐ OIF (Iraq 2003-2010) ☐ OND (Iraq 2010-present)

Diagnosed with: ☐ PTSD ☐ TBI ☐ MST Eligible for VA benefits: ☐ Yes ☐ No ☐ Unsure

APPLICANT NAME: _____

Signify your acknowledgement and acceptance of the following statements by initialing in the spaces provided.

_____ 1. I understand, and acknowledge, that if my application is accepted, I will be required to enter a plea of guilty to the above offenses, or stipulate to the parole/probation violation (if applicable) before the Treatment Court Judge.

_____ 2. I understand, and accept, that by applying to the Treatment Court, I waiving all of my speedy trial rights pursuant to Rule 600 of the Pennsylvania Rules of Criminal Procedure as well as my right to be sentenced, subsequent to my plea of guilty, within ninety (90) days, pursuant to Rule 704 of the Pennsylvania Rules of Criminal Procedure.

_____ 3. I understand and agree to execute all Consents to Release Confidential Information to the Treatment Team regarding any present or past Substance Abuse Treatment Programs, Medical Treatment, Prescribed Medication, and/or any other information the Treatment Court Team may require to create a proper treatment program for me and to monitor the same.

_____ 4. I understand that upon Acceptance I will comply with all the requirements of the Erie County Court of Common Pleas Veterans Treatment Court Program.

The facts set forth in the application are true and correct to the best of my knowledge, information, and belief. I understand that false statements made herein are subject to the penalties of 18 Pa.C.S.A. § 4904 relating to Unsworn Falsification to Authorities.

_____ _____

Signature of Applicant Date