

THE ERIE COUNTY VETERANS 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:
<input type="checkbox"/> Public Defender <input type="checkbox"/> Private/Court Appointed	<input type="checkbox"/> Application completed by Attorney (if applicable)

CRIMINAL/CHARGE INFORMATION -- TO BE COMPLETED BY DEFENSE ATTORNEY			
PLEASE LIST ALL OTNS FOR WHICH YOUR CLIENT IS APPLYING FOR VETERANS TREATMENT COURT:			
Do any of the cases include use or possession of a weapon? <input type="checkbox"/> Yes <input type="checkbox"/> No			

MILITARY HISTORY		
Have you (defendant) ever been in the military? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If no, please complete a Treatment Court application</i>		
Are you receiving VA disability compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Are you registered for healthcare benefits at the VA? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, where? _____</i>		
Branch:	Enlistment Date:	Years of Service:
<input type="checkbox"/> Still serving <input type="checkbox"/> Dishonorable <input type="checkbox"/> Clemency <input type="checkbox"/> Other than honorable <input type="checkbox"/> General (includes medical)		
<input type="checkbox"/> Honorable <input type="checkbox"/> Bad Conduct <input type="checkbox"/> Dismissal <input type="checkbox"/> Entry level separation		
Discharge Date:	Rank at Discharge:	
Are you able to provide your DD-214? <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, would you like assistance with this? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Conflict Era of Service: (Select all that apply)	<input type="checkbox"/> Korea <input type="checkbox"/> ODS (Iraq/Kuwait 1990-2003) <input type="checkbox"/> OIF (Iraq 2003-2010)	<input type="checkbox"/> Vietnam <input type="checkbox"/> OEF (Afghanistan 2001-present) <input type="checkbox"/> OND (Iraq 2010-present)

APPLICANT INFORMATION			
Name:		Alias/Maiden:	
Physical Address:	City	State	Zip Code
Mailing Address: <i>Same as Above</i> <input type="checkbox"/>	City	State	Zip Code

APPLICANT INFORMATION (CONTINUED)

County of Residence:		Currently Incarcerated: <input type="checkbox"/> Yes <input type="checkbox"/> No
		Currently on Prob/Parole: <input type="checkbox"/> Yes <input type="checkbox"/> No
		If yes, where? Officer?
Home Phone:	Cell:	Other:
Email:		Primary language spoken:
Date of Birth:		Social Security Number:
Race: <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Bi-Racial <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Native <input type="checkbox"/> Unknown/Unreported		
Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown/Unreported		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Do you have reliable transportation? <input type="checkbox"/> Yes <input type="checkbox"/> No		Primary source of Transportation:
Do you have a license or ID? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, status: <input type="checkbox"/> Valid <input type="checkbox"/> Suspended <input type="checkbox"/> Expired	License/ID #:
		State Issued:
If revoked/suspended, are you able to regain your driver's license? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Prior participation in a Treatment Court? <input type="checkbox"/> No <input type="checkbox"/> Yes, specify county:		

SUBSTANCE ABUSE HISTORY

Have you ever abused drugs or alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No		Currently abusing? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<i>If no to either of the above, move on to the next section. If yes to either of the above, please complete the following:</i>			
Drug(s) of Choice:	<i>1st</i>	<i>2nd</i>	<i>3rd</i>
Frequency of use:			
Date of last use:			
Amount used:			
Have you ever received any level of treatment for substance abuse disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Are you currently in any level of treatment? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you currently prescribed pharmacological interventions (MATs) for substance abuse? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, list medication(s): <i>(e.g. Methadone, Vivitrol, Suboxone)</i>		
	Where do you receive this medication from?:		

MENTAL HEALTH HISTORY

Prior psychiatric mental health inpatient/outpatient treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No		Currently in M/H treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes to the questions above, was the mental health diagnosis connected to military service? <input type="checkbox"/> Yes <input type="checkbox"/> No		
What is the name of your current MH/MR case manager (if applicable):		
Have you been diagnosed by a medical professional with a mental health disorder? <input type="checkbox"/> No <input type="checkbox"/> Yes, when?		
If yes, who diagnosed you?		Disorder(s) diagnosed?
Are you prescribed any mental health medications? <input type="checkbox"/> No <input type="checkbox"/> Yes		If yes, list medications:

PHYSICAL HEALTH HISTORY

Medical Insurance:	<input type="checkbox"/> County Insurance	<input type="checkbox"/> Private Insurance; specify:
	<input type="checkbox"/> Medicaid/Medicare	<input type="checkbox"/> Other/none
If female, are you pregnant? <input type="checkbox"/> No <input type="checkbox"/> 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):				
<input type="checkbox"/> Any grade up to 11 th	<input type="checkbox"/> GED	<input type="checkbox"/> High School Diploma	<input type="checkbox"/> Some Trade School	
<input type="checkbox"/> Trade School Graduate	<input type="checkbox"/> Some College	<input type="checkbox"/> College Graduate (2 yr)	<input type="checkbox"/> College Graduate (4 yr)	
<input type="checkbox"/> Some Post-Graduate	<input type="checkbox"/> Advanced Degree			
<input type="checkbox"/> Current Student	School:	<input type="checkbox"/> Full-Time	<input type="checkbox"/> Part-Time	
Employment Status (select one):				
<input type="checkbox"/> Unemployed	<input type="checkbox"/> Employed Full-Time (35+ hours/week)		<input type="checkbox"/> Volunteer	
<input type="checkbox"/> Retired	<input type="checkbox"/> Employed Part-Time (<35 hours/week)		<input type="checkbox"/> Disabled	
Employer:		Address:		
Start Date:		Occupation:		
Primary Source of Support (select all that apply):				
<input type="checkbox"/> Adoption Subsidy	<input type="checkbox"/> SSI	<input type="checkbox"/> SSD	<input type="checkbox"/> Welfare	<input type="checkbox"/> None
<input type="checkbox"/> Foster Care Subsidy	<input type="checkbox"/> Retirement Plan	<input type="checkbox"/> Workers Comp	<input type="checkbox"/> Family	<input type="checkbox"/> Other
<input type="checkbox"/> Unemployment	<input type="checkbox"/> Veterans Benefits	<input type="checkbox"/> Salary/Wages	<input type="checkbox"/> Disability	
Housing Status:	<input type="checkbox"/> Independent	<input type="checkbox"/> Dependent (<i>incarcerated, with friends, etc.</i>)		<input type="checkbox"/> Homeless

FAMILY/CHILDREN INFORMATION				
Marital Status:	<input type="checkbox"/> Single	<input type="checkbox"/> Separated	<input type="checkbox"/> Widowed	Name of Paramour/Partner/Spouse:
	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Living Together	
# of Children:	# of Dependent Children:	Custody of all minor children: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		
Visitation rights for children not residing with you? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A			Child support amount (if applicable):	
Currently have contact with your primary family? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A			\$	per month

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 Veterans Treatment Court Judge.
- _____ 2. I understand, and accept, that by Applying to the Veterans 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 Veterans 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