VETERANS TREATMENT COURT

APPLICATION

Application Instructions

1. ***This application can be completed electronically or by printing and filling the application in legible writing, in blue or black ink.***

2. ***Submit your completed application, a copy of your DD214 or Orders and the Signed Release of Information that is included with this application.***

3. ***Email you completed application and documents to erin.lucas@wilco.org and brenda.staples@wilco.org. You may also mail or bring in person your completed application and documents to the Justice Center, 405 Martin Luther King Jr. Street, Box 4, Georgetown, Texas 78626.***

4. ***If tentatively approved, the Program Case Manager will send you and email to set up your orientation and assessments prior to final approval.***

For Questions Contact

Brenda Staples
Specialty Court Coordinator
512-943-1568
brenda.staples@wilco.org

Erin Lucas
Program Case Manager
512-943-1664
erin.lucas@wilco.org

CASE INFORMATION	
Applicant's Name	
Applicant's E-Mail	
Cause Number(s)	
Offense(s)	
Offense Date(s)	
Attorney's Name	
Attorney's Telephone Number and E-Mail	
Court Type and Court Number	Felony_____Misdemeanor_____ Court Number_____
Next Court Setting	

My client is not fluent in English and is requesting an accommodation for the following language: _____.

PART 1: APPLICANT'S PERSONAL DATA SHEET

Personal Information

First Name	**Middle Name**	**Last Name**	
Maiden Name	**Nickname or Alias**	**Date of Birth**	
Highest Education Completed	**Marital Status**	**Number of Dependents**	
Social Security Number	**Driver's License Number**	**DL State**	**DL Expiration**
Race	**Place of Birth**	**Citizenship**	

Residential Address

Address	**Apt #**	**City**	**State**	**Zip Code**

County	**How long have you lived at this physical address?**	**Do you rent or own?**
	Primary Phone Number:	**Secondary Contact Phone Number**

Employment Information

Employment Status (Check One)			
Full-Time	**Part-time**	**Not Employed**	**Disabled**
_____ **Student**	_____ **Retired**	_____**Contractor**	_____ **Homemaker**
Self-Employed			

Employer		**Position/Title**		
Address	**Suite #**	**City**	**State**	**Zip Code**
Work Phone	**Supervisor's Name**		**Length of Employment**	

If you are a student, what school are you attending? _____

If unemployed, when and where were you last employed?_____

PART 2: APPLICANT'S MILITARY AND MEDICAL HISTORY

Military Service Information

Branch of Service (Check one)				
_____ Army	_____Navy	_____Marine	_____Air Force	_____Coast Guard
Service Status (Check one)				
_____Active	_____Reserve	_____Guard	_____Discharged	__Transitioning Out

Type of Discharge? (Check one)					
_____ Honorable	_____ General Under Honorable	____ Other than Honorable	____ Bad Conduct	_____ Dishonorable Discharge	___Dismissal

Rank?	_____	**Dates of Service?**	**Deployments?**
VA Disability Rating?	_____		**Yes_No if yes, dates and locations?**
Combat Injury? If yes, injury details	_____ **Yes** _____ **No**		
Details_____			

Medical Information

Have you been diagnosed with (check all that applies)		
_____TBI_____PTSD_____Anxiety_____Depression		
Other service-connected mental health diagnosis?	**_____ Yes**	**_____No**
List:		
Are you currently in or have you ever been through a substance abuse program?		**_____ Yes_____No**
Type of Program and dates attended?		
_____ Inpatient Dates _____	**_____Outpatient Dates _____**	**_____AA Dates _____**	**_____ NA Dates _____**

Have you had prior treatment for alcohol or substance abuse or mental health treatment?	
Yes No	
Are you currently seeing a doctor?	**Yes No, if yes, please list**
List Names of Doctor(s)?	**Reason for Seeing?**
Are you currently taking medication?	**Yes No, if yes, please list**
Name of Medication	**Reason for Taking this Medication?**

PART 3: PRIOR CONTACTS WITH THE CRIMINAL JUSTICESYSTEM

Prior contacts with the criminal justice system include but are not limited to juvenile records (*regardless of disposition*), adult arrests or citations (*regardless of disposition*), out-of-state arrests or citations (*regardless of disposition*), offenses for Minor in Possession of Alcohol, Minor in Consumption of Alcohol, Public Intoxication, Class “C” Assault, and Possession of Drug Paraphernalia (*regardless of disposition*). The application must be supplemented if contact with the Criminal Justice System occurs after the *Application* is filed. This section does not include traffic citations.

Date of Arrest/Citation	Place of Arrest/Citation	Offense	Disposition

PART 4: DEFENDANT'S STATEMENT OF THE OFFENSE

Please explain in your own words how you believe your experience during military service contributed to the conduct that result in your arrest.

Explain why you want to participate in the program and what you hope the court will help you accomplish.

Attorney of Record

I,_____as attorney of record for Defendant, certify that I have explained to the Defendant he or she must attend and complete a treatment assessment prior to admission into the court. I have also informed the Defendant if he or she is accepted into the program, he or she may be required to pay fees for required classes, ignition interlock (or other alcohol monitoring devices), and any restitution owed on the case (including DPS Lab testing fees). I explained to the Defendant that any weapon seized for any reason as a part of this case may require forfeiture in order to gain admission in into the program.

ATTORNEY FOR DEFENDANT **DATE**

Applicant

I,_____, have been advised by my attorney of record about the Veterans Treatment Court. I understand that the prosecutor may offer me admission into the court on the diversion track or on a probation track. If I am offered acceptance into the court on the diversion track, I understand that I can withdraw from the program at any time and that my case will return to the regular case docket.

I understand that I must complete the required treatment assessment(s) in order for a treatment plan to be developed. I understand failure to attend the assessment or giving false answers during the assessment may result in the denial of my application. I understand the final decision to proceed with or to divert from prosecution of my case rests with the County Attorney's Office.

I certify the information contained in this application is true and correct.

APPLICANT **DATE**

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

PRIVACY ACT INFORMATION: The execution of this form does not authorize the release of information other than that specifically described below. The information requested on this form is solicited under Title 38 U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164; 5 U.S.C. 552a; and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if the information including the last four of your Social Security Number (SSN) and Date of Birth (used to locate records for release) is not furnished completely and accurately, VA will be unable to comply with the request. The Veterans Health Administration may not condition treatment, payment, enrollment or eligibility on signing the authorization. VA may disclose the information that you put on the form as permitted by law. VHA may make a "routine use" disclosure of the information as outlined in the Privacy Act system of records notices identified as 24VA10P2 "Patient Medical Record – VA" and in accordance with the VHA Notice of Privacy Practices. VA may also use this information to identify Veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

TO: DEPARTMENT OF VETERANS AFFAIRS *(Name and Address of VA Health Care Facility)*

1901 S. 1st St.
Temple, TX 76504

LAST NAME- FIRST NAME- MIDDLE INITIAL	LAST 4 SSN	DATE OF BIRTH

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL, OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

Williamson Co. Veterans Treatment court team - all affiliated individuals, agencies, attorneys, and court evaluators. Veteran also agrees to guests of the court/research investigators.

VETERAN'S REQUEST

I request and authorize Department of Veterans Affairs to release the information specified below to the organization, or individual named on this request. I understand that the information to be released includes information regarding the following condition(s):

- [X] DRUG ABUSE
- [ ] SICKLE CELL ANEMIA
- [X] ALCOHOLISM OR ALCOHOL ABUSE
- [ ] TESTING FOR OR INFECTION WITH HUMAN IMMUNODEFICIENCY VIRUS *(HIV)*

DESCRIPTION OF INFORMATION REQUESTED

Check applicable box(es) and state the extent or nature of information to be provided:

- [X] HEALTH SUMMARY *(Prior 2 Years)*
- [X] INPATIENT DISCHARGE SUMMARY *(Dates)*: _____
- [ ] PROGRESS NOTES:
  - [ ] SPECIFIC CLINICS *(Name & Date Range)*: _____
  - [ ] SPECIFIC PROVIDERS *(Name & Date Range)*: _____
  - [ ] DATE RANGE: _____
- [ ] OPERATIVE/CLINICAL PROCEDURES *(Name & Date)*: _____
- [ ] LAB RESULTS:
  - [ ] SPECIFIC TESTS *(Name & Date)*: _____
  - [X] DATE RANGE: All past& future drug & alcohol screens deemed appropriate by the court
- [ ] RADIOLOGY REPORTS *(Name & Date)*: [X] _____

LIST OF ACTIVE MEDICATIONS _____

- [X] OTHER *(Describe)*: Military hx, eligibility for VA services, diagnosis(es), treatment, Meds, attendance & participation in therapy/groups/appts/lab/drug screen results

PURPOSE(S) OR NEED

Information is to be used by the individual for:

- [X] TREATMENT
- [ ] BENEFITS
- [X] LEGAL
- [ ] OTHER *(Specify below)*

_____

LAST NAME- FIRST NAME- MIDDLE INITIAL	LAST 4 SSN	DATE OF BIRTH

AUTHORIZATION

I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing records. Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

I understand that the VA health care provider's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions.

EXPIRATION

Without my express revocation, the authorization will automatically expire.

☐ UPON SATISFACTION OF THE NEED FOR DISCLOSURE

☐ ON _____ *(enter a future date other than date signed by patient)*

☒ UNDER THE FOLLOWING CONDITION(S): Authorization expires upon the discharge of Veteran from the Williamson County Veterans Treatment Court or not to exceed three years.

PATIENT SIGNATURE *(Sign in ink)*	DATE *(mm/dd/yyyy)*

LEGAL REPRESENTATIVE SIGNATURE (*if applicable) (Sign in ink*)	DATE *(mm/dd/yyyy)*

PRINT NAME OF LEGAL REPRESENTATIVE	RELATIONSHIP TO PATIENT

FOR VA USE ONLY

TYPE AND EXTENT OF MATERIAL RELEASED

DATE RELEASED	RELEASED BY:

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

PRIVACY ACT AND PAPER WORK REDUCTION ACT INFORMATION: The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Act. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless is displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 2 minutes. This includes the time it will take to read the instructions, gather the necessary facts and fill out this form. The execution of this form does not authorize the release of information other than that specifically described below.

The information requested on this form is solicited under Title 38 U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164; 5 U.S.C. 552a; and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if information needed to locate records for release is not furnished completely and accurately, VA will be unable to comply with the request. The Veterans Health Administration may not condition the provision of treatment, payment, enrollment in the VA Health Care Program, or eligibility for benefits on the signing of an authorization, except for research-related treatment where an authorization for the use or disclosure of individually-identifiable health information for such research is required. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act system of records notices identified as 24VA10A7 "Patient Medical Record - VA", 08VA05 "Employee Medical File System Records (Title 38)-VA" and in accordance with the Notice of Privacy Practices. VA may also use this information to identify Veterans and person claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

TO: DEPARTMENT OF VETERANS AFFAIRS *(Name and Address of VA Health Care Facility)*

LAST NAME- FIRST NAME- MIDDLE NAME	DATE OF BIRTH *(mm/dd/yyyy)*

PATIENT'S MAILING ADDRESS (*including City, State and Zip Code*)

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL, OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

PURPOSE(S) OR NEED: Information is to be used by the requestor for:

☐ TREATMENT ☐ BENEFITS ☐ LEGAL ☐ EMPLOYMENT ☐ OTHER *(Please specify)* _____

INFORMATION REQUESTED: Check applicable box(es) and state the extent or nature of information to be provided:

☐ HEALTH SUMMARY *(Prior 2 Years)*

☐ INPATIENT DISCHARGE SUMMARY *(Dates)*: _____

☐ PROGRESS NOTES:

- ☐ SPECIFIC CLINICS *(Name & Date Range)*: _____
- ☐ SPECIFIC PROVIDERS *(Name & Date Range)*: _____
- ☐ DATE RANGE: _____

☐ OPERATIVE/CLINICAL PROCEDURES *(Name & Date)*: _____

☐ LAB RESULTS:

- ☐ SPECIFIC TESTS *(Name & Date)*: _____
- ☐ DATE RANGE: _____

☐ RADIOLOGY REPORTS *(Name & Date)*: _____

☐ LIST OF ACTIVE MEDICATIONS: _____

☐ FLU VACCINATION *(Dose, Lot Number, Date & Location)*: _____

☒ OTHER *(Describe)*: DD214

LAST NAME- FIRST NAME- MIDDLE NAME	DATE OF BIRTH *(mm/dd/yyyy)*

SENSITIVE DIAGNOSES: REVIEW AND, IF APPROPRIATE, COMPLETE WHEN RELEASE IS FOR ANY PURPOSE OTHER THAN TREATMENT.

I request and authorize Department of Veterans Affairs to release the information pertaining to the condition(s) below for the non-treatment purpose(s) listed in this authorization.

☐ DRUG ABUSE ☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ SICKLE CELL ANEMIA

☐ HUMAN IMMUNODEFICIENCY VIRUS *(HIV)*

I understand that information on these sensitive diagnoses may be released for treatment purposes without me checking the above boxes, and will be released even if the boxes are unchecked unless I indicate by checking the box below that I do not want this information released for this specific disclosure.

☐ **I do not want sensitive diagnoses released for treatment purposes under this specific authorization. I realize this does not impact other future requests unrelated to this authorization.**

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing records. Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

I understand that the VA health care provider's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions.

EXPIRATION: Without my express revocation, the authorization will automatically expire *(select one of the following)*:

☐ AFTER ONE-TIME DISCLOSURE, IF ALL NEEDS ARE SATISFIED

☐ ON *(mm/dd/yyyy)* _____ *(enter a future date other than date signed by patient)*

☐ UNDER THE FOLLOWING CONDITION(S): _____

_____

PATIENT SIGNATURE *(Sign in ink)*	DATE *(mm/dd/yyyy)*
LEGAL REPRESENTATIVE SIGNATURE *(if applicable) (Sign in ink)*	DATE *(mm/dd/yyyy)*
PRINT NAME OF LEGAL REPRESENTATIVE	RELATIONSHIP TO PATIENT

FOR VA USE ONLY

TYPE AND EXTENT OF MATERIAL RELEASED	
DATE RELEASED *(mm/dd/yyyy)*	RELEASED BY: