

BEAVER COUNTY TREATMENT COURT-APPLICATION

Application must be completed in its entirety, along with all attached releases. 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 OTNS 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:	Alias/Maiden:			
Physical Address:				
Mailing Address: ☐ <i>Street Same as Above</i>				
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		Gender: ☐ Male ☐ Female		
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			
<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? ☐ 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	If yes, list medication(s): <i>(e.g. Methadone, Vivitrol, Suboxone)</i>	
	☐ No	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/MR 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 ☐ Medicaid/Medicare	☐ Private Insurance; specify: ☐ 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 11 th	☐ 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
☐ Foster Care Subsidy	☐ Retirement Plan	☐ Workers Comp	☐ Family
☐ Unemployment	☐ Veterans Benefits	☐ Salary/Wages	☐ Disability
Housing Status:	☐ Independent	☐ Dependent (<i>incarcerated, with friends, etc.</i>)	☐ Homeless

FAMILY/CHILDREN INFORMATION	
Marital Status:	☐ Single ☐ Married
	☐ Separated ☐ Divorced
	☐ Widowed ☐ 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	Child support amount (if applicable): \$ per month
Currently have contact with your primary family? ☐ Yes ☐ No ☐ N/A	

MILITARY HISTORY	
Have you (defendant) ever been in the military? ☐ Yes ☐ No <i>If yes, please answer the questions below.</i>	
Branch:	Enlistment Date: Years of Service:
☐ Still serving	☐ Dishonorable
☐ Honorable	☐ Bad Conduct
☐ Clemency	☐ Dismissal
☐ Other than honorable	☐ Entry level separation
☐ General (includes medical)	
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:
Diagnosed with:	☐ PTSD ☐ TBI ☐ MST
Eligible for VA benefits:	☐ Yes ☐ No ☐ Unsure

APPLICANT NAME: _____

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

- _____ 1. I understand and acknowledge my acceptance that by submitting this Application, I am waiving my Preliminary Hearing in regard to the above listed case(s).
- _____ 2. 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 before the Treatment Court Judge.
- _____ 3. 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.
- _____ 4. I understand and agree to execute all Consents to Release Confidential Information to the Drug 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 design a proper treatment program for me and to monitor the same.
- _____ 5. I understand and acknowledge that upon filing this Application with the Clerk of Courts, I will not need to attend any further hearings on the cases involved with this application pending a notification of acceptance or rejection into the Treatment Court Program.
- _____ 6. However, I also understand and acknowledge if this application is for Reconsideration for admission into the Treatment Court Program, until I receive notice of acceptance or rejection into the Treatment Court Program, I will continue to appear at all proceedings in my case(s).
- _____ 7. I understand and acknowledge that upon acceptance into the Treatment Court Program, this case will be continued generally pending the successful completion or termination of my Treatment Court Treatment Program.
- _____ 8. I understand and acknowledge should my application be rejected, my case(s) shall continue through the normal criminal procedure process. However, since I have waived my preliminary hearing in order to file this Application, upon its rejection I will have the option of remanding this case for a preliminary hearing or may choose to file a habeas corpus petition.
- _____ 9. I understand that upon Acceptance I will comply with all the requirements of the Beaver County 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

DO NOT COMPLETE THIS SECTION - OFFICIAL COORDINATOR USE ONLY		
Date(s) Distributed for Review		
Received:	DA:	SCA/VJO:

**Beaver County
Treatment Court Release
Consent to Release Confidential Information**

Client Name _____

DOB _____

Address _____

Phone # _____

I (client) give my consent to the following:

- | | |
|--|--|
| ☐ Beaver County Drug & Alcohol | ☐ Beaver County Public Defender's Office |
| ☐ BCBH Mental Health Unit | ☐ Beaver County Treatment Court Coordinator |
| ☐ Beaver County Courts | ☐ Beaver County District Attorney |
| ☐ Beaver County Adult Probation | |

To communicate with and disclose to one another the following information:

- ☐ Verbal information regarding the coordination of services for Beaver County Treatment Court
- ☐ Other _____

Reason for Disclosure:

- ☐ For agencies indicated above to coordinate services for Beaver County Treatment Court at the request of client
- ☐ Other _____

This authorization expires as indicated (if no indication is provided, authorization will be in effect for 365 days).

☐ Specify date or event _____

I understand that:

- I have the right to revoke this authorization at any time in writing. However, the revocation of this authorization will not affect the disclosure of any information that has already been sent to the individuals/organizations listed above.
- In accordance with 4 PA code 255.5 (b), Drug & Alcohol treatment information to be released to judges, probation or parole officers, insurance companies, health or hospital plans, or governmental officials shall be restricted to the following: (1) Whether the client is or is not in treatment, (2) The prognosis of the client, (3) The nature of the program, (4) A brief description of the progress of the client, (5) A short statement as to whether the client has relapsed into drug or alcohol abuse and the frequency of such relapse.
- The agencies listed above may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization.
- I am entitled to a copy of this completed authorization form.

**Beaver County
Treatment Court Release
Consent to Release Confidential Information
- Continued -**

PART B

Drug & Alcohol information will be disclosed as protected by Federal Confidentiality rules (42 CFR Part 2). The Federal rules prohibit the individual/organization identified in Part A of this form 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 CFR Part 2. A general authorization for the release of 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.

Mental Health and HIV/AIDS information will be disclosed as protected by Pennsylvania law. Pennsylvania law prohibits further disclosures of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or is authorized by the Confidentiality of HIV-Related Information Act. A general authorization for the release of medical or other information is not sufficient for this purpose.

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I have been offered a copy of this form and I have: ☐Accepted ☐Refused

Signature of Client/Legal Representative

Date

Signature of Staff/Witness Representative

Date

REVOCATION STATEMENT:

I, _____ have REVOKED this consent

on _____