Unified Judicial System

Pennington County Veterans Court Application

Return to: Treatment Court Coordinator Ashlee May at
Ashlee.May@ujs.state.sd.us or the Pennington County Court Services Office

Date of Application:	Referring Party:
Disability accommodations? ☐No ☐Yes	Accommodations Needed:
Interpreter needed? ☐No ☐Yes	Language Needed:
Full Name:	Date of Birth:
Other Names Used:	Gender:
Race:	Ethnicity: ☐Hispanic ☐Non-Hispanic ☐Unknown
Phone Number:	Email Address:
Current living arrangements: ☐Own ☐Rent ☐Hotel/Motel ☐With Friend/Family ☐Jail ☐Homeless	
Address:	
City:	State: / Zip Code:
Emergency Contact:	Relationship:
Address:	Phone Number:
Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed ☐Co-Habitating	
Significant Other:	
Address:	Phone Number:
Pregnant: ☐No ☐Yes ☐Yes-Significant Other	Paying Child Support: ☐N/A ☐No ☐Yes
Number of Children Under Age 18:	Number of Children Over Age 18:

Children

Full Name:	Date of Birth:	Full Name:	Date of Birth:

Other Members of the Household

Full Name:	Full Name:	Full Name:

Driver's License Status: ☐None ☐Expired ☐Revoked ☐Suspended ☐Valid | ☐ID ONLY	
Driver's License Number:	State:
State ID Number:	State:

Highest Grade Completed:	☐ High School Diploma ☐ GED ☐ College Degree
Service the Military or Armed Forces? ☐ No ☐ Yes	Received Veterans Services? ☐ No ☐ Yes
Branch:	Discharge Date:
Rank at Discharge:	Discharge Reason:

Primary Source of Income:	Monthly Income: $
Employer:	Supervisor:
Address:	Phone Number:
Assistance/Benefits: ☐ None ☐ WIC ☐ TANF ☐ VA ☐ LIEAP ☐ Child Support ☐ SSI SSD ☐ Voc Rehab ☐ Unemployment ☐ Food Stamps ☐ Medicaid ☐ Housing Assistance ☐ Other	

Drugs of Choice: 1)	2)	3)
Current IV Drug Use: ☐ No ☐ Yes	History of IV Drug Use: ☐ No ☐ Yes	
History of Overdose: ☐ No ☐ Yes	Drug of Overdose:	Date of Overdose:
Previous Treatment: ☐ None ☐ Detox ☐ Inpatient ☐ IOP ☐ Outpatient ☐ Jail-Based ☐ Individual ☐ Co-Occurring ☐ Inpatient Mental Health ☐ Outpatient Mental Health		
Currently in Treatment: ☐ No ☐ Yes	Where:	

Treatment Needs Assessment completed within the past 6 months: ☐ No ☐ Yes
If YES — Provide a copy to the Treatment Court Coordinator

Medical Insurance: ☐ None ☐ Medicaid ☐ Medicare ☐ VA ☐ Federal ☐ State ☐ Private

Mental Health Provider:	**Medical Provider:**
List all MENTAL HEALTH diagnoses:	List all MEDICAL conditions:
List all MENTAL HEALTH medications:	List all MEDICAL medications:

Number of Law Enforcement Contacts:	Age of First Arrest:	
Current Charges:		BAC, if applicable:
Defense Attorney:		
Are you currently on probation? ☐ No ☐ Yes	Probation Officer:	
Previous **Treatment Court** Participation? ☐ No ☐ Yes	Court:	When:
Have you ever been sentenced to prison: ☐ No ☐ Yes	When:	

The Treatment Court Team will determine whether you are eligible for the program. **By signing this application, you agree to allow court services officers, treatment providers and mental health providers to conduct necessary interviews to determine eligibility and share that information with the rest of the team.** By signing below, the applicant acknowledges that she/he has had an opportunity to discuss this matter with counsel and that she/he understands her/his Boykin rights, and freely and voluntarily agrees to participate in the process required to create the Level of Service Inventory (LSI) and to that end waives his/her Boykin rights for the purpose of completing the LSI.

Applicant Signature	Date	Defense Attorney Signature	Date