Unified Judicial System

2nd Circuit DUI Court Application

Return to: Treatment Court Coordinator Nichole Larive at nichole.larive@ujs.state.sd.us

Date of Application:	Referring Party:	
Criminal File No.:	Charges:	BAC, if available:
Previous **Treatment Court** Participation? ☐No ☐Yes	Court:	When:
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:	
Address:		
City:	State:	Zip Code:
Driver's License Status: ☐None ☐Expired ☐Revoked ☐Suspended ☐Valid ☐ID ONLY		
Driver's License Number:	State:	
State ID Number:	State:	
Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed ☐Co-Habitating		
Primary Source of Financial Support:		Monthly Income: $
Are you currently on probation? ☐No ☐Yes	Probation Officer:	
Are you currently on parole? ☐No ☐Yes	Parole Officer:	
Number of Law Enforcement Contacts:	Age of First Arrest:	
Have you ever been sentenced to prison: ☐No ☐Yes	When:	
Current living arrangements: ☐Own ☐Rent ☐Hotel/Motel ☐With Friend/Family ☐Jail ☐Homeless		
Service the Military or Armed Forces? ☐No ☐Yes	Received Veterans Services? ☐No ☐Yes	
Military Status: ☐Current Member ☐Honorable Discharge ☐Dishonorable Discharge ☐Other Than Honorable Discharge ☐Bad Conduct ☐Other: _____		
Branch of Service:	Rank at Discharge:	
Discharge Date:	Discharge Reason:	
Pregnant: ☐No ☐Yes ☐Yes-Significant Other	#/Children Under Age 18:	#/Children Over Age 18:
Paying Child Support: ☐N/A ☐Current ☐Paying, not current ☐Not paying		
#/Children living with you:	#/Children living with other relative:	#/Children in foster care:
#/Children living independently:	#/Children you had your parental rights terminated or relinquished:	

List all MEDICAL conditions:						
Prescribed medication in the past year: ☐No ☐Yes				Taking medication as prescribed? ☐No ☐Yes		
List ALL medications:						
Medical Insurance: ☐None ☐Medicaid ☐Medicare ☐VA ☐Federal ☐State ☐Private						
List all MENTAL HEALTH diagnoses:						
Previous Treatment Services: ☐None ☐Detox ☐Inpatient ☐IOP ☐Outpatient ☐Jail-Based ☐Individual ☐Co-Occurring ☐Inpatient Mental Health ☐ Outpatient Mental Health						
History of Overdose: ☐No ☐Yes	Drug of Overdose:			Date of Overdose:		
Drugs of Choice:	1)		2)		3)	
Current IV Drug Use: ☐No ☐Yes				History of IV Drug Use: ☐No ☐Yes		
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**						
Employment Status: ☐Unemployed ☐Employed Full Time ☐Employed Part Time ☐Self-Employed ☐Student ☐Disabled ☐Retired ☐Volunteer ☐Other: _____						
Employer:				Start-Date:		
Supervisor:				Phone Number:		
Address:						
Emergency Contact:				Relationship:		
Emergency Contact Address:				Phone Number:		
Significant Other:						
Significant Other Address:				Phone Number:		
Highest Grade Completed:	☐High School Diploma ☐GED ☐Vocational Training ☐2 Year College Degree ☐4 Year College Degree ☐Advanced College Degree					

CHILDREN

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

Assistance/Benefits:	☐None ☐WIC ☐TANF ☐VA ☐LIEAP ☐Child Support ☐SSI SSD ☐Voc Rehab ☐Unemployment ☐Food Stamps ☐Medicaid ☐Housing Assistance ☐Other: _____

Other Members of the Household		
Full Name:	Full Name:	Full Name:
Defense Attorney:		

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

CONSENT FOR DISCLOSURE OF CONFIDENTIAL SUBSTANCE ABUSE TREATMENT INFORMATION

I, , having agreed to enroll and participate in the Treatment Court Program, hereby acknowledge that treatment information normally is confidential under federal law. I understand that any disclosure made is bound by Part 2 of Title 42 of the Code of Federal Regulations, which governs the confidentiality of substance abuse patient (or client) records, and Part 164 of Title 45 of the CFR, which governs the confidentiality of mental and physical health records generally. I also understand that it is unlawful to violate these confidentiality requirements, but that both requirements permit me to voluntarily consent to permit disclosure of my health and substance abuse treatment information.

Therefore, I, , consent to allow the release of employment, medical, psychiatric, treatment, educational, mental health, or other documents and records that are deemed necessary for Treatment Court purposes concerning Case No(s). . I also consent to the disclosure of on-going communications about my diagnosis, prognosis, and compliance status, which includes, but is not limited to, the following:

- Assessment results pertaining to Treatment Court eligibility, treatment needs, and supervision needs;
- Attendance at scheduled appointments;
- Attendance at support group meetings;
- Drug and alcohol test results, including efforts to defraud or invalidate drug or alcohol tests;
- Attainment of treatment plan goals, such as completion of a required counseling regimen;
- Evidence of symptom resolution, such as reductions in drug cravings or withdrawal symptoms;
- Evidence of treatment-related attitudinal improvements, such as increased insight or motivation for change;
- Attainment of Treatment Court phase requirements, such as obtaining and maintaining employment or enrolling in an educational program;
- Compliance with electronic monitoring, home curfews, travel limitations, and geographic or association restrictions;
- Adherence to legally prescribed and authorized medically assisted treatments;
- Procurement of unauthorized prescriptions for addictive or intoxicating medications;
- Commission of or arrests for new offenses; and
- Menacing, threatening, or disruptive behavior with staff members, fellow participants or other persons.

These communications may be disclosed among the following parties or agencies involved in the Treatment Court Program: the Treatment Court judge, the Treatment Court team members, the employees engaged in the Treatment Court operations and administration, court services officers

in the Treatment Court Program, treatment providers utilized by me during the Treatment Court Program, the Treatment Court defense attorney, and/or other referring or treating agencies involved in the direct delivery of services through the Treatment Court Program.

I understand that the purpose of and the need for this disclosure is to: inform the court and the other above-specified agencies of my eligibility and/or acceptability for substance abuse treatment services; to report on and adequately monitor my treatment, attendance, prognosis, and compliance with the terms and conditions of the program; to discuss and assess my status as a Participant in the Treatment Court Program; and, to assess and comment on my progress in accordance with the Treatment Court's reporting and monitoring criteria.

I agree to permit the disclosure of this confidential information only as necessary for, and pertinent to, hearings, and/or reports concerning the status of my participation and compliance with the conditions of my probation as defined by the Treatment Court. I understand that information about my medical status, mental health and/or drug treatment status, my arrest history, my levels of compliance or non-compliance with the conditions of my Treatment Court participation (including the results of urinalysis or other drug screening tools,) and other material information will be discussed and shared among members of the Treatment Court Team.

I further understand that as an essential component of the Treatment Court Program summary information about my compliance or non-compliance will be discussed in an **open and public courtroom**, including but not limited to, whether I have attended all meetings, treatment sessions, the results of urinalysis or other drug testing as required, and the disclosure of my compliance or noncompliance with the terms and conditions of the Program as defined by the Court. It is entirely possible that third parties will attend these court sessions and will hear these discussions. This process will require the redisclosure of confidential treatment information to individuals who have not been individually and specifically authorized to receive such information. Therefore, **I hereby specifically consent to any potential redisclosure to third persons who may be in attendance at any of my Treatment Court sessions.**

I further understand that if I re-disclose confidential information of any other participant to another party, I expose myself to legal liability for unauthorized disclosure of confidential information.

Recipients of this confidential information may re-disclose it only in connection with their official duties***. I understand that this consent will remain in effect and cannot be revoked by me until there has been a formal and effective termination of my involvement with the Treatment Court for the case named above such as the discontinuation of all court-ordered supervision or probation upon my successful completion of the Treatment Court requirements, or upon sentencing for violating the terms of my Treatment Court involvement.***

_____ Date _____
Treatment Court Participant

_____ Date _____
Witness

Publicity Consent/Release

I accept and approve the use, print, and copy of all media by the Treatment Court. This includes all pictures or videos taken of me. My name may or may not be included for media, promotional, educational, and other purposes. I realize this coverage may use my picture, with or without further explanation. This could be alone or with other pictures, in a story, on a website, or on a cover of any or all public materials for Treatment Court.

I release the Treatment Court, its staff and employees, or anyone it authorizes, from all claims relating to or arising from the use of the consented items above.

I am over eighteen years of age. I have read this agreement or have had it read and explained to me. I fully understand what it means. I have signed this on my own free will without force.

Name: _____

Address: _____

City: _____

State: _____

Zip Code: _____

Telephone: _____

This consent/release will remain in effect until revoked by me in writing. I understand that the consent/release cannot be revoked by me until:

- Successful completion of the Treatment Court
- Discharge from court-ordered supervision or probation
- Termination of my involvement with the Treatment Court
- Sentencing for violating the terms of my Treatment Court involvement

_____ _____

Date Signature

SOUTH DAKOTA PRESCRIPTION DRUG MONITORING PROGRAM

The South Dakota Prescription Drug Monitoring Program gathers data from dispensers who serve South Dakota residents and makes it available to prescribers and pharmacists to enable them to make better decisions when providing controlled substances to their patients. In addition, law enforcement can access this tool to reduce doctor-shopping, prescription forgery, and the diversion of prescription medications into illegitimate channels. All controlled substances in Schedules II – IV are tracked by the South Dakota Prescription Drug Monitoring Program.

I, , having agreed to enroll and participate in the Treatment Court program, hereby acknowledge that treatment information normally is confidential under federal law. I understand that any disclosure made is bound by Part 2 of Title 42 of the Code of Federal Regulations (CFR), which governs the confidentiality of substance abuse patient (or client) records, and Part 164 of Title 45 of the CFR, which governs the confidentiality of mental and physical health records generally. I also understand that it is unlawful to violate these confidentiality requirements, but that both requirements permit me to voluntarily consent to permit disclosure of my health and substance abuse treatment information.

Therefore, I, give consent to (court services officer and Team) to obtain my prescription drug monitoring program data from the South Dakota Pharmacy Board for the purpose of assisting the Treatment Court team with my case, specifically for supervision and treatment. All information obtained through the South Dakota Prescription Drug Monitoring Program will be kept confidential by the Treatment Court Team. ***I understand that this consent will remain in effect and cannot be revoked by me until there has been a formal and effective termination of my involvement with the Treatment Court for the case named above such as the discontinuation of all court-ordered supervision or probation upon my successful completion of the Treatment Court requirements, or upon sentencing for violating the terms of my Treatment Court involvement.***

Signature _____ Date_____

Witness Signature_____ Date_____

Treatment Court Testing Agreement

While in the Treatment Court program, the following criteria will be met:

- I will use my own urine or bodily fluids for all tests.
- Tests will be held on a frequent and random basis including weekends and holidays.
- I have the right to dispute test results at my own expense.
- I will be given a time and location to report for testing.
- I must have a working phone so I can be reached on at any time.
- If I am late or do not show up for a test, I can receive a sanction.
- If I do not give a urine sample or if I give a diluted sample, it is a positive test.
- I may be sanctioned for being with or around other people who use drugs or alcohol.
- I will not use any products that can change a urine sample.
- I can be sanctioned for using substances that avoid detection on tests.
- I can be subject to instant testing if there is reason to suspect recent use.
- If over the counter medication is used, it may be a positive test. I can be sanctioned.
- It is my duty to inform my doctor that I am in a Treatment Court. I will need to provide my court services officer with a doctor's note. If I do not, I may be sanctioned.
- This consent cannot be revoked until there has been a formal and effective termination with the Treatment Court.

Participant Signature: _____

Date: _____

Witness Name Printed: _____

Witness Signature: _____

Date: _____