



Unified Judicial System

Second Circuit Problem Solving Court Program

If there are ANY competency concerns **do not** proceed.

- There are four Problem-Solving Courts. Those courts are Veteran's Court, Drug Court, DUI Court, and Mental Health Court. Each has eligibility conditions that will be discussed with you by your lawyer.
- Applicants who apply are considered for the program on a case-by-case basis. The Judge of the specific Court decides whether to accept or deny all applications.
- Applicants must live within the Minnehaha & Lincoln Counties.

Drug Court eligibility includes but not limited to:

- ❖ Must be 18 or Older
- ❖ Cannot be required to be registered as a sex offender
- ❖ Must pass legal screening

Mental Health Court eligibility includes but not limited to:

- ❖ Must be 18 or Older
- ❖ Cannot be required to be registered as a sex offender
- ❖ Must pass legal screening
- ❖ Must meet SMI & IMPACT Criteria (Please see your attorney if you have questions)
- ❖ Must live within the City of Sioux Falls

Veteran's Court eligibility includes but not limited to:

- ❖ Must be 18 or Older
- ❖ Cannot be required to be registered as a sex offender
- ❖ Must pass legal screening
- ❖ Must have prior service in US Military

DUI Court eligibility includes but not limited to:

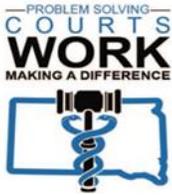
- ❖ Must be 18 or Older
- ❖ Cannot be required to be registered as a sex offender
- ❖ Must pass legal screening

ALL PAGES of this packet should be returned to:
Problem Solving Court Coordinator at Court Services
425 N Dakota Ave
Sioux Falls, SD 57104

Unified Judicial System
Second Circuit
Problem-Solving Court Program

I intend to apply to the following Court (select the ONE that best fits): <input type="checkbox"/> Drug <input type="checkbox"/> DUI <input type="checkbox"/> Veterans <input type="checkbox"/> Mental Health			
Disability accommodations request? <input type="checkbox"/> Yes <input type="checkbox"/> No		Accommodations Requested:	
Interpreter needed? <input type="checkbox"/> Yes <input type="checkbox"/> No		Language Requested:	
Name:		Date of Birth:	
Other Names Used:		Gender:	
Race:		Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown	
Phone Number:		Email Address:	
Current living arrangements: <input type="checkbox"/> Renting <input type="checkbox"/> Hotel/Motel <input type="checkbox"/> With Friend/Family <input type="checkbox"/> Jail <input type="checkbox"/> Homeless			
Current Physical Address:			
City:		State:	Zip Code:
How long at this address?		Other states lived in:	
Do any other adults live with you? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Do you have your Photo ID: <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you have your Social Security Card: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Driver's License Status: <input type="checkbox"/> None <input type="checkbox"/> Expired <input type="checkbox"/> Revoked <input type="checkbox"/> Suspended <input type="checkbox"/> Valid			
Driver's License Number:		State:	
State ID Number:		State:	
Service in the U.S. Armed Forces? <input type="checkbox"/> Yes <input type="checkbox"/> No		Branch:	Discharge:
Next of Kin:		Relationship:	
Address:		Phone Number:	
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Cohabiting			
Significant Other:			
Address:		Phone Number:	
Do you have any children? <input type="checkbox"/> Yes <input type="checkbox"/> No			
How many under age 18:		How many over age 18:	
Do any of your children live with you? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Primary Source of Income:		Monthly Income: \$	
Employer:		Supervisor:	
Address:		Phone Number:	

Drugs of Choice:	
Current IV drug user: <input type="checkbox"/> Yes <input type="checkbox"/> No	Past IV drug user: <input type="checkbox"/> Yes <input type="checkbox"/> No
Addiction Treatment Needs Assessment completed within the past 6 months: <input type="checkbox"/> Yes <input type="checkbox"/> No ***If YES — Where: _____	
Do you have a Mental Health Provider? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have a Medical Provider: <input type="checkbox"/> Yes <input type="checkbox"/> No
Provider Name:	Medical Provider:
Are you on any psychotropic medication? <input type="checkbox"/> Yes <input type="checkbox"/> No	Other prescription medication? <input type="checkbox"/> Yes <input type="checkbox"/> No
Highest Grade Completed:	<input type="checkbox"/> High School Diploma <input type="checkbox"/> GED <input type="checkbox"/> College Degree
Age of first arrest:	Gang Affiliation:
Number of lifetime MISDEMEANOR arrests:	Number of lifetime FELONY arrests:
Number of lifetime MISDEMEANOR convictions:	Number of lifetime FELONY convictions:
Current Case Number(s):	
Defense Attorney:	
Currently on Probation: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Previous Problem-Solving Court participation: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name of Court:	When:
Have you ever been sentenced to prison: <input type="checkbox"/> Yes <input type="checkbox"/> No	When:
<p>The Problem-Solving Court Team needs information to determine your eligibility for the program. By signing this application, you agree to let team members share your information before you plead guilty. The information shared will include Application information, LSI-R (risk/Needs Assessment) score, Mental Health records, and Treatment Needs Assessments.</p>	
Applicant Signature _____	Date _____



ACKNOWLEDGEMENT AND APPLICATION CONSENT

(To be signed with lawyer and sent to Court Coordinator after legal screening)

Name: _____ Date of Birth: _____

Case Number(s): _____

1. I am satisfied with my lawyer's explanation of the program to which I am applying. They have explained my rights, and legal consequences of applying to the problem-solving court.
2. My lawyer has explained the potential legal consequences if I don't successfully complete the program.
3. I will fill out and submit consents and waivers and will submit any other requested documentation such as medical or treatment records.
4. I will be required to keep all scheduled appointments. These appointments must be completed before the Problem-Solving Court Team will consider my application.
 - Treatment Needs Assessment to be completed by the designated provider(s) (i.e. VOA, Southeastern Behavioral, Carroll Institute, Veterans Healthcare and Mental Health, etc.)
 - The Court Services Office will call you to schedule a LSI-R (Risk/Needs Assessment)
 - IF APPLYING TO VETERAN'S COURT – ATTACH DD214 or NGB-22

***My lawyer will receive notification of acceptance or denial into the program.**

If I am accepted into the program, I must complete certain forms and waivers, which are included in the Participant Manual for the specific Court to which I am applying.

Problem-Solving Court Applicant

Date

Defense Attorney

Date



CONSENT FOR DISCLOSURE OF CONFIDENTIAL TREATMENT INFORMATION

I, _____, having agreed to enroll and participate in the Problem-Solving 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 from the following entities:

1. Minnehaha County Jail
2. Mental Health Treatment Providers at _____
3. Substance Abuse Treatment Providers at _____

Therefore, I consent to allow the release of employment, medical, psychiatric, treatment, educational, mental health, or other documents and records which are deemed necessary for Problem-Solving 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 eligibility, treatment needs, and supervision needs;
- Attendance at scheduled appointments;
- 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 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.
- Current list of medications and history of compliance in taking them.

These communications may be disclosed among the following parties or agencies involved in the Problem-Solving Court Program: the Problem-Solving Court judge, the Problem-Solving Court team members, the employees engaged in the Problem-Solving Court operations and administration, court services officers in the Problem-Solving Court Program, treatment providers utilized by me during the Problem-Solving Court Program, the Problem-Solving Court defense attorney, and/or other referring or treating agencies involved in the direct delivery of services through the Problem-Solving 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 Problem-Solving Court Program; and, to assess and comment on my progress in accordance with the Problem-Solving Court 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 Problem-Solving 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 Problem-Solving 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 Problem-Solving Court team.

I further understand that as an essential component of the Problem-Solving 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 attend any of my Problem-Solving 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 the course of 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 Problem-Solving Court for the case named above such as the discontinuation of all court-ordered supervision or probation upon my successful completion of the Problem-Solving Court requirements, or upon sentencing for violating the terms of my Problem-Solving Court involvement.

Problem-Solving Court Applicant

Date

Witness

Date



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 SD PDMP.

I, _____, having agreed to enroll and participate in the Problem-Solving 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 the Problem-Solving Court Coordinator and Team to obtain my Prescription Drug Monitoring Program data from the South Dakota Pharmacy Board for the purpose of assisting the Problem-Solving Court with my case, specifically for supervision and treatment. All information obtained through the PDMP program will be kept confidential between the Problem-Solving 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 Problem-Solving Court for the case named above such as the discontinuation of all court-ordered supervision or probation upon my successful completion of the Problem-Solving Court requirements, or upon sentencing for violating the terms of my Problem-Solving Court involvement.

Problem-Solving Court Applicant

Date

Witness

Date