



Unified Judicial System

VETERANS COURT SECOND CIRCUIT Court Application

Return to: Treatment Court Coordinator Rhiannon Weber at rhiannon.weber@uj.s.sd.us

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| Date of Application: | | Referring Party: | |
| Criminal File No.: | Charges: | BAC, if available: | |
| Previous Treatment Court Participation? <input type="checkbox"/> No <input type="checkbox"/> Yes | Court: | When: | |
| Disability accommodations? <input type="checkbox"/> No <input type="checkbox"/> Yes | Accommodations Needed: | | |
| Interpreter needed? <input type="checkbox"/> No <input type="checkbox"/> Yes | Language Needed: | | |
| Full 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: | | |
| Address: | | | |
| City: | State: | Zip Code: | |
| Driver's License Status: <input type="checkbox"/> None <input type="checkbox"/> Expired <input type="checkbox"/> Revoked <input type="checkbox"/> Suspended <input type="checkbox"/> Valid <input type="checkbox"/> ID ONLY | | | |
| Driver's License Number: | | State: | |
| State ID Number: | | State: | |
| 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"/> Co-Habiting | | | |
| Primary Source of Financial Support: | | | Monthly Income: \$ |
| Are you currently on probation? <input type="checkbox"/> No <input type="checkbox"/> Yes | | Probation Officer: | |
| Are you currently on parole? <input type="checkbox"/> No <input type="checkbox"/> Yes | | Parole Officer: | |
| Number of Law Enforcement Contacts: | | Age of First Arrest: | |
| Have you ever been sentenced to prison: <input type="checkbox"/> No <input type="checkbox"/> Yes | | When: | |
| Current living arrangements: <input type="checkbox"/> Own <input type="checkbox"/> Rent <input type="checkbox"/> Hotel/Motel <input type="checkbox"/> With Friend/Family <input type="checkbox"/> Jail <input type="checkbox"/> Homeless | | | |
| Service the Military or Armed Forces? <input type="checkbox"/> No <input type="checkbox"/> Yes | | Received Veterans Services? <input type="checkbox"/> No <input type="checkbox"/> Yes | |
| Military Status: <input type="checkbox"/> Current Member <input type="checkbox"/> Honorable Discharge <input type="checkbox"/> Dishonorable Discharge <input type="checkbox"/> Other Than Honorable Discharge <input type="checkbox"/> Bad Conduct <input type="checkbox"/> Other: _____ | | | |
| Branch of Service: | | Rank at Discharge: | |
| Discharge Date: | | Discharge Reason: | |
| Pregnant: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Yes-Significant Other | #/Children Under Age 18: | | #/Children Over Age 18: |
| Paying Child Support: <input type="checkbox"/> N/A <input type="checkbox"/> Current <input type="checkbox"/> Paying, not current <input type="checkbox"/> 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: | |

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| List all MEDICAL conditions: | | | | | |
| Prescribed medication in the past year: <input type="checkbox"/> No <input type="checkbox"/> Yes | | | Taking medication as prescribed? <input type="checkbox"/> No <input type="checkbox"/> Yes | | |
| List ALL medications: | | | | | |
| Medical Insurance: <input type="checkbox"/> None <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> VA <input type="checkbox"/> Federal <input type="checkbox"/> State <input type="checkbox"/> Private | | | | | |
| List all MENTAL HEALTH diagnoses: | | | | | |
| Previous Treatment Services: <input type="checkbox"/> None <input type="checkbox"/> Detox <input type="checkbox"/> Inpatient <input type="checkbox"/> IOP <input type="checkbox"/> Outpatient <input type="checkbox"/> Jail-Based <input type="checkbox"/> Individual <input type="checkbox"/> Co-Occurring <input type="checkbox"/> Inpatient Mental Health <input type="checkbox"/> Outpatient Mental Health | | | | | |
| History of Overdose: <input type="checkbox"/> No <input type="checkbox"/> Yes | | Drug of Overdose: | | Date of Overdose: | |
| Drugs of Choice: | 1) | 2) | 3) | | |
| Current IV Drug Use: <input type="checkbox"/> No <input type="checkbox"/> Yes | | | History of IV Drug Use: <input type="checkbox"/> No <input type="checkbox"/> Yes | | |
| Currently in Treatment: <input type="checkbox"/> No <input type="checkbox"/> Yes | | Where: | | | |
| Treatment Needs Assessment completed within the past 6 months: <input type="checkbox"/> No <input type="checkbox"/> Yes If YES — Provide a copy to the Treatment Court Coordinator | | | | | |
| Employment Status: <input type="checkbox"/> Unemployed <input type="checkbox"/> Employed Full Time <input type="checkbox"/> Employed Part Time <input type="checkbox"/> Self-Employed <input type="checkbox"/> Student <input type="checkbox"/> Disabled <input type="checkbox"/> Retired <input type="checkbox"/> Volunteer <input type="checkbox"/> 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: | | <input type="checkbox"/> High School Diploma <input type="checkbox"/> GED <input type="checkbox"/> Vocational Training <input type="checkbox"/> 2 Year College Degree <input type="checkbox"/> 4 Year College Degree <input type="checkbox"/> Advanced College Degree | | | |
| CHILDREN | | | | | |
| Full Name: | Date of Birth: | Gender: | Full Name: | Date of Birth: | Gender: |
| | | | | | |
| | | | | | |
| | | | | | |
| Assistance/Benefits: <input type="checkbox"/> None <input type="checkbox"/> WIC <input type="checkbox"/> TANF <input type="checkbox"/> VA <input type="checkbox"/> LIEAP <input type="checkbox"/> Child Support <input type="checkbox"/> SSI SSD <input type="checkbox"/> Voc Rehab <input type="checkbox"/> Unemployment <input type="checkbox"/> Food Stamps <input type="checkbox"/> Medicaid <input type="checkbox"/> Housing Assistance <input type="checkbox"/> Other: _____ | | | | | |

| Full Name: | | Other Members of the Household Full Name: | | Full Name: | |
|------------|--|--|--|------------|--|
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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.

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| Applicant Signature | Date | Defense Attorney Signature | Date |
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