Unified Judicial System

Sixth Circuit Treatment Court Application

Return to: Treatment Court Coordinator Nicholas Wiebe at Nicholas.Wiebe@ujs.state.sd.us or Court Services, PO Box 454, Fort Pierre, SD 57532.

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:
Next of Kin:	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:

Insurance: ☐No ☐Yes	Insurance Company and policy number:

Assistance/Benefits: ☐None ☐WIC ☐TANF ☐VA ☐LIEAP ☐Child Support ☐SSI SSD ☐Voc Rehab ☐Unemployment ☐Food Stamps ☐Housing Assistance ☐Other ☐Medicaid (provide number): ☐Medicare Part A/B/C/D (provide part and number):

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

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

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 Charges:

Defense Attorney:

Are you currently on probation? ☐No ☐Yes (Mark yes if currently on probation in South Dakota, another state and/or tribal or federal probation.)	Probation Officer: Office Location: Probation start date:	
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 team members to share your information (for eligibility purposes) before you plead guilty.** The information shared will include the application (signed by you and your defense attorney), the results of a risk and needs assessment (LSI-R/IDA, completed by a CSO), and a Treatment Needs Assessment (completed by a licensed counselor).

Applicant Signature	Date	Defense Attorney Signature	Date