



Unified Judicial System

Codington County Treatment Court Application

Return to: Treatment Court Coordinator
Tiffany Barthel at Tiffany.Barthel@uj.s.sd.us

Date of Application:		Referring Party:	
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:	
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			
Address:			
City:		State:	Zip Code:
Emergency Contact:		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"/> Co-Habiting			
Significant Other:			
Address:		Phone Number:	
Pregnant: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Yes-Significant Other		Paying Child Support: <input type="checkbox"/> N/A <input type="checkbox"/> No <input type="checkbox"/> 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: <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:	

Highest Grade Completed:		<input type="checkbox"/> High School Diploma <input type="checkbox"/> GED <input type="checkbox"/> College Degree	
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	
Branch:		Discharge Date:	
Rank at Discharge:		Discharge Reason:	
Primary Source of Income:		Monthly Income: \$	
Employer:		Supervisor:	
Address:		Phone Number:	
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			
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	
History of Overdose: <input type="checkbox"/> No <input type="checkbox"/> Yes		Drug of Overdose: _____	Date of Overdose: _____
Previous Treatment:		<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	
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			
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			
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? <input type="checkbox"/> No <input type="checkbox"/> Yes		Probation Officer:	
Previous Treatment Court Participation? <input type="checkbox"/> No <input type="checkbox"/> Yes		Court:	When:
Have you ever been sentenced to prison: <input type="checkbox"/> No <input type="checkbox"/> Yes		When:	
<p>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.</p>			
Applicant Signature _____		Defense Attorney Signature _____	
Date _____		Date _____	