



Unified Judicial System

Yankton County Treatment Court Application

Return to: Treatment Court Coordinator Sharon Kraft at
410 Walnut Street, Ste. 203, Yankton, SD 57078

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:	

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: _____					

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
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