Unified Judicial System

Pennington County Drug Court Application

Return to: Treatment Court Coordinator Ashlee May at
Ashlee.May@ujs.state.sd.us or the Pennington County Court Services Office

Date of Application:	Referring Party:	
Criminal File No.:	Charges:	BAC, if available:
Previous **Treatment Court** Participation? ☐No ☐Yes	Court:	When:
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:	
Address:		
City:	State:	Zip Code:
Driver's License Status: ☐None ☐Expired ☐Revoked ☐Suspended ☐Valid ☐ID ONLY		
Driver's License Number:	State:	
State ID Number:	State:	
Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed ☐Co-Habitating		
Primary Source of Financial Support:		Monthly Income: $
Are you currently on probation? ☐No ☐Yes	Probation Officer:	
Are you currently on parole? ☐No ☐Yes	Parole Officer:	
Number of Law Enforcement Contacts:	Age of First Arrest:	
Have you ever been sentenced to prison: ☐No ☐Yes	When:	
Current living arrangements: ☐Own ☐Rent ☐Hotel/Motel ☐With Friend/Family ☐Jail ☐Homeless		
Service the Military or Armed Forces? ☐No ☐Yes	Received Veterans Services? ☐No ☐Yes	
Military Status: ☐Current Member ☐Honorable Discharge ☐Dishonorable Discharge ☐Other Than Honorable Discharge ☐Bad Conduct ☐Other: _____		
Branch of Service:	Rank at Discharge:	
Discharge Date:	Discharge Reason:	
Pregnant: ☐No ☐Yes ☐Yes-Significant Other	#/Children Under Age 18:	#/Children Over Age 18:
Paying Child Support: ☐N/A ☐Current ☐Paying, not current ☐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: ☐No ☐Yes				Taking medication as prescribed? ☐No ☐Yes		
List ALL medications:						
Medical Insurance: ☐None ☐Medicaid ☐Medicare ☐VA ☐Federal ☐State ☐Private						
List all MENTAL HEALTH diagnoses:						
Previous Treatment Services: ☐None ☐Detox ☐Inpatient ☐IOP ☐Outpatient ☐Jail-Based ☐Individual ☐Co-Occurring ☐Inpatient Mental Health ☐ Outpatient Mental Health						
History of Overdose: ☐No ☐Yes	Drug of Overdose:			Date of Overdose:		
Drugs of Choice:	1)		2)		3)	
Current IV Drug Use: ☐No ☐Yes				History of IV Drug Use: ☐No ☐Yes		
Currently in Treatment: ☐No ☐Yes	Where:					
Treatment Needs Assessment completed within the past 6 months: ☐No ☐Yes **If YES — Provide a copy to the Treatment Court Coordinator**						
Employment Status: ☐Unemployed ☐Employed Full Time ☐Employed Part Time ☐Self-Employed ☐Student ☐Disabled ☐Retired ☐Volunteer ☐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:	☐High School Diploma ☐GED ☐Vocational Training ☐2 Year College Degree ☐4 Year College Degree ☐Advanced College Degree					

CHILDREN

Full Name:	Date of Birth:	Gender:	Full Name:	Date of Birth:	Gender:

Assistance/Benefits:	☐None ☐WIC ☐TANF ☐VA ☐LIEAP ☐Child Support ☐SSI SSD ☐Voc Rehab ☐Unemployment ☐Food Stamps ☐Medicaid ☐Housing Assistance ☐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