

Approved/Denied/Referred to other Treatment Court

Case # \_\_\_\_\_

OTN \_\_\_\_\_

Probation/Parole Violation: YES/NO

### APPLICATION FOR TREATMENT COURT

Please check the appropriate court you are applying for:

Mental Health Court: \_\_\_\_\_

-----  
**NAME** \_\_\_\_\_ **AGE** \_\_\_\_\_

**DATE OF BIRTH** \_\_\_\_\_ **S.S.#** \_\_\_\_\_

**ADDRESS** \_\_\_\_\_ **PHONE** \_\_\_\_\_

**CITY** \_\_\_\_\_ **STATE** \_\_\_\_\_ **ZIP** \_\_\_\_\_

Length at present address: \_\_\_\_\_ List below **five** years prior residences:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Place of Employment \_\_\_\_\_ Medical Insurance: Y or N

Do you have a **valid** driver's license? Y or N If no, why? \_\_\_\_\_

Driver's license #/state: \_\_\_\_\_

Date of Arrest \_\_\_\_\_ Blood Alcohol Content (BAC) \_\_\_\_\_

Are you currently on Probation/Parole? \_\_\_\_\_ State or County: \_\_\_\_\_ In Jail? \_\_\_\_\_

List all current charges: \_\_\_\_\_

Prosecuting Agency/Officer: \_\_\_\_\_ District Justice: \_\_\_\_\_

Attorney Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Drug User: \_\_\_\_\_ Drug Choice: \_\_\_\_\_ Length of Use: \_\_\_\_\_

Alcohol User: \_\_\_\_\_ Frequency: \_\_\_\_\_ Length of Use: \_\_\_\_\_

Mental Health Issues/Diagnosis: \_\_\_\_\_

Physician: \_\_\_\_\_ Medications: \_\_\_\_\_

Caseworker: \_\_\_\_\_ Who referred you to this program? \_\_\_\_\_

Are you currently attending counseling or involved in any programs? \_\_\_\_\_

List Agency \_\_\_\_\_

\*Date of Formal Arraignment: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Referral Source Signature: \_\_\_\_\_ Date: \_\_\_\_\_

For Official Use Only. Do not write in the space below.

_____	_____	_____
Application Rec'd	Sent to DA	Sent for Assessment
_____	_____	_____
Police Liaison	Assessment Compl.	To Committee

**DISTRICT ATTORNEY ELIGIBILITY**

RECOMMENDED:

NOT RECOMMENDED:  
(WHY?)

COMMENTS:



**LYCOMING-CLINTON MENTAL HEALTH/MENTAL RETARDATION PROGRAM  
AUTHORIZATION FOR RELEASE OF INFORMATION**

**The Sharwell Building**  
200 East Street  
Williamsport, PA 17701

**8 North Grove Street**  
Lock Haven, PA 17745

I authorize the use/disclosure of information about me as described below:

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Social Security # \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_ Day Phone: \_\_\_\_\_

**PROVIDER/REQUESTOR: I AUTHORIZE LYCOMING-CLINTON MH/MR PROGRAM TO:**

**RELEASE TO:** OR  **RECEIVE FROM:**

Provider/Requestor \_\_\_\_\_  
Name \_\_\_\_\_ Address \_\_\_\_\_

**INFORMATION TO BE DISCLOSED:** Dates of Treatment from \_\_\_\_\_ to \_\_\_\_\_

<input type="checkbox"/> Psychological Evaluation	<input type="checkbox"/> Psychosocial History	<input type="checkbox"/> Psychiatric Evaluation
<input type="checkbox"/> Social History	<input type="checkbox"/> Medical History/Records	<input type="checkbox"/> School Records
<input type="checkbox"/> Drug and Alcohol History	<input type="checkbox"/> Progress Reports	<input type="checkbox"/> Discharge Summary
<input type="checkbox"/> Financial Benefits/Records	<input type="checkbox"/> DPA Benefits	<input type="checkbox"/> Social Security Benefits
<input type="checkbox"/> Insurance/Pension	<input type="checkbox"/> VA Benefits	<input type="checkbox"/> Other:

**SPECIAL AUTHORIZATION:** My evaluation, diagnosis, and/or treatment may be released to the requestor noted above as indicated by my initials next to the information to be released.

Behavioral Health       HIV/AIDS       Alcohol and/or drug abuse or dependence

**REASON FOR THE RELEASE:**

Insurance       Legal       Continued Care  
 Personal       Other Specified:

**REVOCAATION:**

I understand that I may revoke this authorization in writing at any time by sending written notification to the provider. I understand that any such revocation is not effective to the extent that action has been taken in reliance on this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by state or federal law.

I understand that providing authorization for the requested use or disclosure is not a condition of my treatment, payment, enrollment in a health plan or eligibility for benefits except (1) if my treatment is related to research; or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

This authorization shall be in force and effect until \_\_\_\_\_. (Note: must specify (a) an expiration date; or (b) an expiration event that relates to the individual or the purpose of the use or disclosure. The statement "end of research study," "none," or similar language is sufficient if the authorization is for a use or disclosure of protected health information for research, including for the creation and maintenance of a research database or research repository).

**AUTHORIZATION:**

I authorize the provider to release the information above to the requestor.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**IF PATIENT IS UNABLE TO CONSENT BECAUSE OF AGE OR PHYSICAL CONDITION, PLEASE COMPLETE ONE OF THE FOLLOWING:**

Patient (is a minor \_\_\_ years of age) OR (is unable to give consent because \_\_\_\_\_)

Patient Representative's Signature \_\_\_\_\_ Relationship \_\_\_\_\_ Date: \_\_\_\_\_

**This information has been disclosed to you from records whose CONFIDENTIALITY is protected by State Law. Pennsylvania State Regulations prohibit you from making any further disclosure of this information without the prior written consent of person with respect to whom it pertains.**



**ADDRESS AND PHONE NUMBER**

PHYSICAL RESIDENTIAL ADDRESS

HOUSE TYPE: \_\_\_\_\_  
STREET AND NUMBER: \_\_\_\_\_  
APARTMENT NUMBER: \_\_\_\_\_  
CITY: \_\_\_\_\_  
STATE: \_\_\_\_\_  
ZIP CODE: \_\_\_\_\_  
COUNTY: \_\_\_\_\_  
TOWNSHIP/BOROUGH: \_\_\_\_\_  
TIME AT PRESENT ADDRESS: \_\_\_\_\_  
ANY PETS? (IF YES, LIST TYPE AND QUANTITY): \_\_\_\_\_

MAILING ADDRESS

SAME AS PHYSICAL ADDRESS?  YES  NO  
(IF NO, THEN FILL OUT BELOW)

HOUSE TYPE: \_\_\_\_\_  
STREET AND NUMBER: \_\_\_\_\_  
APARTMENT NUMBER: \_\_\_\_\_  
CITY: \_\_\_\_\_  
STATE: \_\_\_\_\_  
ZIP CODE: \_\_\_\_\_  
COUNTY: \_\_\_\_\_  
TOWNSHIP/BOROUGH: \_\_\_\_\_

PHONE NUMBERS

MOBILE/CELL PHONE: \_\_\_\_\_  
HOME PHONE: \_\_\_\_\_  
OTHER PHONE: \_\_\_\_\_

**HEALTH/MEDICAL**

SERIOUS MEDICAL CONDITIONS?  YES (EXPLAIN BELOW)  NO

LIST HERE: \_\_\_\_\_

MENTAL HEALTH ISSUES?  YES (EXPLAIN BELOW)  NO

LIST HERE: \_\_\_\_\_

CURRENT PRESCRIBED MEDICATIONS?  YES (EXPLAIN BELOW)  NO

LIST HERE: \_\_\_\_\_  
\_\_\_\_\_

**EMERGENCY CONTACTS:**

**CONTACT 1**

NAME: \_\_\_\_\_  
LAST FIRST MIDDLE

DATE OF BIRTH: \_\_\_\_\_

STREET AND NUMBER: \_\_\_\_\_

APARTMENT NUMBER: \_\_\_\_\_

CITY: \_\_\_\_\_

STATE: \_\_\_\_\_

ZIP CODE: \_\_\_\_\_

COUNTY: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_

RELATIONSHIP TO YOU: \_\_\_\_\_





**CRIMINAL HISTORY**

EVER CONVICTED OF SEXUAL OFFENSE?  YES  NO  
(IF CHECKED FILL OUT INFORMATION BELOW)

LIST OFFENSE AND YEAR COMMITTED: \_\_\_\_\_  
\_\_\_\_\_

MEGAN'S LAW OFFENDER?  YES  NO

IF YES:  TIER 1  TIER 2  TIER 3  OTHER

DEEMED A SEXUALLY VIOLENT PREDATOR?  YES  NO

**EDUCATION**

**HIGH SCHOOL:**

NAME OF HIGH SCHOOL ATTENDED: \_\_\_\_\_

DID YOU GRADUATE HIGH SCHOOL?  YES \_\_\_\_\_  NO  
If Yes, Year Completed (IF NO, FILL OUT BELOW)

HIGHEST GRADE COMPLETED: \_\_\_\_\_

DID YOU OBTAIN YOUR GED  YES  NO

**HIGHER EDUCATION/TRADE SCHOOL**

DID YOU ATTEND COLLEGE OR TRADE SCHOOL?  YES  NO  
(IF YES, FILL OUT BELOW)

NAME OF COLLEGE OR TRADE SCHOOL ATTENDED: \_\_\_\_\_

DID YOU GRADUATE?  YES  NO

IF YES, HIGHEST COMPLETED:  CERTIFICATE  ASSOCIATES  BACHELORS  MASTERS  DOCTORATE

YEAR COMPLETED: \_\_\_\_\_

IF NO, HIGHEST LEVEL COMPLETED: \_\_\_\_\_

**EMPLOYMENT**

LEGALLY ABLE TO WORK?  YES  NO

EMPLOYMENT STATUS  FULL TIME  PART TIME  DISABLED  RETIRED  STUDENT  UNEMPLOYED

EMPLOYER NAME: \_\_\_\_\_

EMPLOYER ADDRESS: \_\_\_\_\_

EMPLOYER PHONE: \_\_\_\_\_

POSITION HELD: \_\_\_\_\_

LENGTH OF EMPLOYMENT: \_\_\_\_\_

AVERAGE INCOME/WEEK: \_\_\_\_\_

IF UNEMPLOYED, HOW LONG? \_\_\_\_\_

IF UNEMPLOYED, WHY? \_\_\_\_\_

**GANGS**

HAVE YOU EVER BEEN IN A GANG?  YES  NO  
(IF YES, FILL OUT BELOW)

LIST GANG AFFILIATION: \_\_\_\_\_

**MILITARY SERVICE**

EVER SERVE IN MILITARY  YES  NO  
(IF YES, FILL OUT BELOW)

BRANCH SERVED: \_\_\_\_\_

YEAR DISCHARGED: \_\_\_\_\_

DISCHARGE STATUS  HONORABLE  OTHER THAN HONORABLE/DISHONORABLE

**DRIVERS LICENSE/ ID**

DO YOU HAVE A DRIVERS  
LICENSE?

YES  
(IF YES, FILL OUT BELOW)

NO

DRIVERS LICENSE NUMBER/STATE: \_\_\_\_\_

IS YOUR LICENSE VALID

YES

NO

IF NO, WHY NOT? \_\_\_\_\_

DO YOU HAVE A STATE ID?

YES  
(IF YES, FILL OUT BELOW)

NO

STATE ID NUMBER/STATE: \_\_\_\_\_

**VEHICLE INFORMATION**

DO YOU OWN A VEHICLE?

YES  
(IF YES, FILL OUT BELOW)

NO

MAKE: \_\_\_\_\_

MODEL: \_\_\_\_\_

YEAR: \_\_\_\_\_

COLOR: \_\_\_\_\_

LICENSE PLATE NUMBER: \_\_\_\_\_

**WEAPONS:**

ARE YOU PERMITTED TO POSSESS FIREARMS?

YES

NO

DO YOU HAVE FIREARMS OR OTHER DEADLY WEAPONS IN YOUR HOME?

YES

NO

ARE YOU TRAINED IN HAND-TO-HAND COMBAT?

YES

NO

**OTHER INCOME/ENTITLEMENTS**

DO YOU RECEIVE  
UNEMPLOYMENT, DISABILITY,  
OR RETIREMENT

YES  
(IF YES, FILL OUT BELOW)

NO

SPECIFY TYPE AND AMOUNT RECEIVED: \_\_\_\_\_

DO YOU RECEIVE FOOD  
STAMPS, WELFARE, OR OTHER  
PUBLIC ASSISTANCE?

YES  
(IF YES, FILL OUT BELOW)

NO

SPECIFY TYPE AND AMOUNT RECEIVED: \_\_\_\_\_