LYCOMING COUNTY VETERANS COURT APPLICATION

COMMONWEALTH OF PENNSYLVANIA :
: Docket/Case Number(s): _____
vs. : _____
: _____
Name: _____ :

This form will be reviewed by the Veterans Court Committee to determine your eligibility for admission into the Veterans Court Program.

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1. PERSONAL INFORMATION

Name(s): _____

Date of Birth: _____ Social Security Number: _____

Driver's License Number or Photo Identification Number: _____

Status of Driver's License: _____

Address: _____

Telephone Number: _____ Cell Phone Number: _____

Highest Level Education Completed: _____

Source(s) of Income (Employment/VA/SSI/SSD): _____ Amount: $_____

Employer Information and Occupation (name/address/phone):

_____

_____

Are you a citizen of the United States? ☐ Yes ☐ No if not, what type of visa do you hold? _____

Current Housing Status: _____

2. LEGAL INFORMATION

Attorney Name: _____

Address & Phone: _____

What are the current charges against you? _____
Are you currently in incarcerated? ☐ Yes ☐ No

If yes, where: _____

Are there other charges pending against you, including those in other counties or states? ☐ Yes ☐ No

If yes, please explain:

Have you ever been convicted of a misdemeanor or felony offense? ☐ Yes ☐ No

If yes, please explain: _____

_____

_____

_____

Are you currently on probation or parole? ☐ Yes ☐ No If yes, what is the name of your probation/parole officer? _____

Have you applied for or participated in any treatment court programs in this or any other county? _____

If yes, what county(ies)? _____

3. MILITARY STATUS

For Veterans only:

What were your dates of service? _____

What branch of the military did you serve? Were you deployed? _____
If yes to the above, indicate where and when. ☐ Yes ☐ No
What was your rank at discharge? What is your discharge status? _____
Did you serve in combat? _____
If yes to the above, indicate where and when. _____
Do you have access to your **DD-214**? _____

☐ Yes ☐ No

_____

☐ Yes ☐ No ***If yes, please send with application**

Do you currently receive Veteran's benefits? ☐ Yes ☐ No

For Active Duty Military only:

When did you begin service? _____

What branch of the military do you serve? _____ Were you deployed? _____

If yes to the above, indicate where and when. ☐ Yes ☐ No

What is your rank? _____

Have you served in combat? _____

If yes to the above, indicate where and when. _____

☐ Yes ☐ No

_____

4. MEDICAL HISTORY

Do you have any medical conditions that affect your daily lifestyle? ☐ Yes ☐ No

If yes, please explain:

Please list **ALL** your medications prescribed (including over the counter medication and Medically Assisted Treatment prescriptions):

1._____ 2._____ 3._____ 4._____

5._____ 6._____ 7._____ 8._____

Are you being seen at the VA for Medical Care? ☐ Yes ☐ No If yes, where? _____

Do you have a primary care doctor in the community/outside of the VA? ☐ Yes ☐ No

5. SUBSTANCE USE INFORMATION

Have you ever abused drugs or alcohol? ☐ Yes ☐ No

Current substance abuse: ☐ Yes ☐ No

If yes, list the type/amount/frequency: _____

Primary Drug of Choice: _____

Secondary Drug of Choice: _____

Third Drug of Choice: _____

IV Drug User: ☐ Yes ☐ No

History of IV Drug ☐ Use: Yes ☐ No

Age Began Using Drugs: _____

Years of Drug Use: _____

Age Began Using Alcohol: _____

Years of Alcohol Abuse: _____

Have you ever participated in substance use treatment? ☐ Yes ☐ No

If yes, please identify where and when: _____

_____

6. MENTAL HEALTH HISTORY

Have you ever been treated for a mental illness? ☐ Yes ☐ No

If yes, have you ever received mental health services (type/when/where): _____

_____

Present Diagnosis _____

_____

Past Diagnosis _____

_____

Are you currently prescribed medications for your mental illness? ☐ Yes ☐ No

If yes, please name your current psychiatric medications and the prescribing doctor and dosage/frequency:

_____

_____

_____

Are you taking your medications as prescribed? ☐ Yes ☐ No

If no, why? _____

_____

Were you prescribed psychiatric medications before incarceration? ☐ Yes ☐ No

If yes, name the psychiatric medications you were prescribed in the past and the prescribing doctor and dosage/frequency: _____

_____

_____

List your most recent mental health hospitalization(s) including date and facility, if applicable: _____

_____

List the name of your current MH/ID/EI case manager, if applicable: _____

7. REFERRAL SOURCE INFORMATION

Name, Agency, Title and Contact Information of Referral Source:

_____

Who completed this Application? (Printed name): _____ (Date): _____

8. OTHER

Are there any court proceedings ongoing or that you are involved in the last 10 years? ("Court orders" include, but are not limited to: protection from abuse (PFA) orders; bench warrants; support orders; other judgments.)

☐ Yes ☐ No If yes, please identify the order(s):

9. VETERAN'S STATEMENTS

1. I, _____, have read the Lycoming County Veterans Court Policy with the assistance of _____ (Defense Counsel), who explained the Veterans Court program to me and answered my questions.

2. I have attached a copy of my **DD-214. (If you are not able to submit a copy of your DD-214 with this application by completing this application you are giving consent for our court team to obtain a copy of your DD-214 to verify your veteran's status.)**

3. I agree to abide by the General Orders of Veterans Court, which are:

   I. To conduct myself at all times with the dignity and honor that is befitting a veteran or an active member of the United States armed forces.

   II. To be honest and forthright with the Veterans Court Team and myself at all times, and to use the resources available to me when I begin experiencing triggers, symptoms or negative thought patterns.

   III. To take charge of any addictive or criminal behaviors and mental health issues that is keeping me from becoming a productive, healthy and active member of society.

   IV. To comply at all times with the requirements of the Veterans Court program and to report any violations of the program rules to my probation officer immediately.

   V. To work as part of a team, accepting the help of professionals and my fellow veterans to successfully recover mentally, physically, spiritually, and socially.

4. **The facts set forth in the application are true and correct to the best of my knowledge, information, and belief. I understand that false statements herein made are subject to the penalties of 18 Pa.C.S. §4904 relating to Unsworn Falsification to Authorities.**

_____ _____

Signature Date

This application is to be completed and submitted to:

President Judge Nancy L. Butts
Veterans Treatment Court Judge
48 West Third Street
Williamsport PA 17701

If you have any questions about the application process or the program, contact the Adult Probation Office at (570) 327-2385.

THE WEST BRANCH DRUG AND ALCOHOL ABUSE COMMISSION
CASE MANAGEMENT UNIT
CONSENT OF RELEASE CONFIDENTIAL INFORMATION

I, _____, do hereby consent to and authorize the West Branch Drug and Alcohol Abuse Commission Case Management Unit, to, as indicated below release to:

_____
Name of person/agency

_____
Address/Telephone

the following information pertaining to myself. The information to be disclosed is:

___Whether the client is or is not in treatment
___The nature of the project
___Whether or not the client has relapsed
___The Prognosis/Diagnosis of the client
___A Brief Description of the client's progress
___Other (specify) _____

The information is needed for the following purpose:

___Referral for treatment services
___To monitor the provision of ongoing treatment
___To enable judges, attorneys, probation/parole officers to support treatment goals and/or make legal decisions on the client's behalf
___To obtain insurance, employment or government benefits
___Referral to intensive case management
___Other (specify) _____

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR, part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or other drug abuse patient.

I may revoke this consent to release information at any time except to the extent that action has been taken in reliance of it. When applicable, criminal justice system clients who have agreed to enter treatment in lieu of prosecution or punishment may not revoke their consent that allows the court, probation, parole, or other criminal justice agency from monitoring their progress in treatment.

_____I have been offered a copy of this document and I have ____Accepted
____Refused

_____
Signature of client Date

_____
Signature of witness Date

_____
Specify date, event or condition upon which release will expire.

THE WEST BRANCH DRUG AND ALCOHOL ABUSE COMMISSION
CASE MANAGEMENT UNIT
CONSENT OF RELEASE CONFIDENTIAL INFORMATION

I, _____, do hereby consent to and authorize the West Branch Drug and Alcohol Abuse Commission Case Management Unit, to, as indicated below release to:

Lycoming County Courts
Name of person/agency

48 West Third Street Williamsport, PA 17701 (570) 327-2338
Address/Telephone

the following information pertaining to myself. The information to be disclosed is:

_X_ Whether the client is or is not in treatment
_X_ The nature of the project
_X_ Whether or not the client has relapsed
_X_ The prognosis/diagnosis of the client
___ A brief description of the client's progress
___ Other (specify) _____

The information is needed for the following purpose:

___ Referral for treatment services
_X_ To monitor the provision of ongoing treatment
_X_ To enable judges, attorneys, probation/parole officers to support treatment goals and/or make legal decisions on the client's behalf
___ To obtain insurance, employment or government benefits
___ Referral to intensive case management
___ Other (specify) _____

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR, part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or other drug abuse patient.

I may verbally or in writing revoke this consent to release information at any time except to the extent that action has been taken in reliance of it. When applicable, criminal justice system clients who have agreed to enter treatment in lieu of prosecution or punishment may not revoke their consent that allows the court, probation, parole, or other criminal justice agency from monitoring their progress in treatment.

_____ I have been offered a copy of this document and I have ____ Accepted
____ Refused

_____
Signature of client Date

_____
Specify date, event or condition upon which release will expire.

Revised 10/5/23

Department of Veterans Affairs	REQUEST FOR AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

PRIVACY ACT AND PAPER WORK REDUCTION ACT INFORMATION: The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Act. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless is displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 2 minutes. This includes the time it will take to read the instructions, gather the necessary facts and fill out this form. The execution of this form does not authorize the release of information other than that specifically described below.

The information requested on this form is solicited under Title 38 U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164; 5 U.S.C. 552a; and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if the information including the last four of your Social Security Number (SSN) and Date of Birth (used to locate records for release) is not furnished completely and accurately, VA will be unable to comply with the request. The Veterans Health Administration may not condition treatment, payment, enrollment or eligibility on signing the authorization. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act system of records notices identified as 24VA10P2 "Patient Medical Record – VA", 08VA05 "Employee Medical File System Records (Title 38)-VA" and in accordance with the Notice of Privacy Practices. VA may also use this information to identify veterans and person claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

TO: DEPARTMENT OF VETERANS AFFAIRS (Name and address of VA health care facility):
Wilkes Barre VA Medical Center
1111 East End Blvd
Wilkes Barre, PA 18711

LAST NAME-FIRST NAME-MIDDLE INITIAL	LAST 4 SSN	DATE OF BIRTH

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL, OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED
Lycoming County Veterans Court and Problem Solving Adult and Juvenile Courts Information System (PAJCIS)

PURPOSE(S) OR NEED: Information is to be used by the organization or individual for

☒ Treatment ☐ Benefits ☒ Legal ☐ Employment ☒ Other – Please specify. Verification of eligibility;

Summary of assessed treatment plan,status of progress through treatment including UDS results for TX purposes

INFORMATION REQUESTED: Check applicable box(es) and state the extent or nature of information to be provided:

- ☐ Health Summary (prior 2 years)
- ☐ Inpatient Discharge Summary (dates): _____
- ☐ Progress Notes:
  - ☐ Specific clinics (name & date range): _____
  - ☐ Specific providers (name & date range): _____
  - ☐ Date range: _____
- ☐ Operative/Clinical Procedures (name &date): _____
- ☐ Lab results:
  - ☐ Specific tests (name & date): _____
  - ☐ Date range: _____
- ☐ Radiology Reports (name & date): _____
- ☐ List of Active Medications
- ☐ Flu Vaccination (dose, lot number, date & location)
- ☒ Other (describe below): Verification of eligibility; summary of assessed treatment plan, status of progress through treament including UDS results utilized for treatment purposes

LAST NAME-FIRST NAME-MIDDLE INITIAL	LAST 4 SSN	DATE OF BIRTH

SENSITIVE DIAGNOSES: REVIEW AND, IF APPROPRIATE, COMPLETE WHEN RELEASE IS FOR ANY PURPOSE OTHER THAN TREATMENT.

I request and authorize the Department of Veterans Affairs to release the information pertaining to the condition(s) below for the non-treatment purpose(s) listed in this authorization:

☒ Drug Abuse ☒ Alcoholism or Alcohol Abuse ☐ Sickle Cell Anemia
☐ Human Immunodeficiency Virus (HIV)

I understand that information on these sensitive diagnoses may be released for treatment purposes without me checking the above boxes, and will be released even if the boxes are unchecked unless I indicate by checking the box below that I do not want this information released for this specific disclosure.

☐ **I do not want sensitive diagnoses released for treatment purposes under this specific authorization. I realize this does not impact other future requests unrelated to this authorization.**

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion, or because a condition of VA employment mandates the signing of this authorization. The information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing records. Any information disclosed per this authorization may no longer be protected by Federal confidentiality laws or regulations and may be subject to re-disclosure by the recipient.

I understand that the VA health care provider's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions.

EXPIRATION: Without my express revocation, the authorization will automatically expire

☐ After one-time disclosure, if all needs are satisfied
☐ On _____ (enter a future date other than date signed by patient)
☒ Under the following condition(s): Successful completion or termination of the program

PATIENT SIGNATURE	DATE (mm/dd/yyyy)
LEGAL REPRESENTATIVE SIGNATURE (if applicable)	**DATE (mm/dd/yyyy)**
PRINT NAME OF LEGAL REPRESENTATIVE	**RELATIONSHIP TO PATIENT**

FOR VA USE ONLY

Type and Extent of Material Released:
Weekly verbal reports as well as updates on medications, treatment plan changes, and treatment compliance.

Date Released:	Released by: