

Approved/Denied/Referred to other Treatment Court

Case# _____

OTN _____

Probation/Parole Violation: YES/NO

APPLICATION FOR TREATMENT COURT

Please check the appropriate treatment court you are applying for:

Drug Court _____ DUI 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: _____ 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: _____

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

Application Rec'd Sent to D.A. Sent for Assessment

Police Liaison Assessment Compl. To Committee

DISTRICT ATTORNEY ELIGIBILITY

RECOMMENDED:

NOT RECOMMENDED:
(WHY?)

COMMENTS:

**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:

- 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.