Guadalupe County
Veterans Treatment Court Application

The Guadalupe County Veterans Treatment Court ("VTC") Participant Handbook has been read and you understand the program and what's expected of you during the course of the program?

Yes / No; if no, please read the handbook before you proceed.
(circle one)

This is a treatment court, and it takes about 18 months to 2 years to complete the program; which includes, but is not limited to:

- weekly Seeking Safety meetings (Wednesday evenings at the Seguin DAV) – provided by mentor volunteers
- monthly appointments with your VTC probation officer – a member of the VTC team
- monthly appointments with the VJO (location appointments in Seguin, NB or SA) – a member of the VTC team, or private counselor
- community hours related to veteran programs
- specialized DWI, Drug, Anger Management type classes and/or therapy or classes relative to your particular case
- attending Veterans Treatment Court

By signing here, you are stating you have read the handbook and understand the rules and consequences.

____
Signature

Last Name: ____________________ First Name:____________________ Middle Name:__________________

Aliases/Maiden Name: ______________________________________ Male / Female

Email:______________________________ Arrest Date:____________________ Inmate No.:___________________

Do you have an interlock? Yes / No; If yes; please list the company:____________________________

Case (circle one): Felony or Misdemeanor Case No.:_________________________

Do you currently have an attorney? Yes / No; If yes; name:______________________________________

Is your attorney (circle one): Hired by You – or – Court Appointed

Mobile Phone Number: ________________________ Alternate Phone Number: _______________________

Date of Birth: ____________________ Social Security No.:____________________________________

Do you live in Guadalupe County? Yes / No; If no; name County of Residence:_________________

Physical Address: ____

City: ____________________________ State: Texas Zip: _______________ County:_______________________

Mailing Address (only if different from Physical Address): ____

City: ___________________________ State: Texas Zip: ___________ County:________________

Marital Status: ____________ In a relationship? Yes / No; If yes; name:___________________

Who else resides in your household? ____

How many children do you have? _______ List all their names, age & name of other parent:

Name:	Age	Other Parent:
______________________	______	________________________________
______________________	______	________________________________
______________________	______	________________________________
______________________	______	________________________________
______________________	______	________________________________

Emergency Contact Information:

Last Name: __________________ First Name:______________ Relationship:_____________

House Phone Number: ________________________ Cell Phone: _______________________

Physical Address: ____

City: _______________________ State: Texas Zip: _________ County:_____________

Military Service:

Army Navy Marine Air Force Coast Guard Reserves National Guard

Dates of Service: ______________ to _______________ Highest Rank: __________________

Type of Discharge: ______________________________ Rank at Discharge: _______________

Where did you serve? ____

____

____

Have you served in Combat? Yes / No - If yes to combat; how many times?_______________

Did you receive any Article 15/Disciplinary Actions/Military convictions? Yes / No - If yes, describe: ____

Education:

Highest level of education: ___HS Diploma ___GED ___College ___Vocational Training

List all degrees or certificates:____

____

Driver's License:

Do you have a valid driver's license? Yes / No If no, why not?__________________________

If yes; Driver's License No.:________________________ State Issued: _______________

Occupation:

Are you currently employed?: Yes / No Employer: ______________________________________

Retired?: Yes / No Retired from:_____________________________________

Work Phone: ___________________________ Work Address: ___________________________

Work schedule:____

Financial Status:

Your Monthly Income: $_______________

List Debts: ____

____

List Assets: ____

____

Substance Abuse/Mental Health/Medical:

Are you currently receiving substance abuse treatment? Yes / No

Have you ever previously received substance abuse treatment? Yes / No

Are you currently receiving mental health treatment? Yes / No

Have you ever previously received mental health treatment? Yes / No

List any existing diagnoses: ____

Are you eligible to receive services from the VA? Yes / No / Don't know

Do you currently receive any services from the VA? Yes / No

If yes, where? ____________________ Describe:______________________________________

Do you have a service connected disability? ____ Yes ____ No If so, Disability Rating_______

List Current Medications (names, dosage & how often):

Prescription name:	Dosage	Often	Taken for:	Doctor:
___________________	________	______	________________	______________
___________________	________	______	________________	______________
___________________	________	______	________________	______________
___________________	________	______	________________	______________
___________________	________	______	________________	______________
___________________	________	______	________________	______________
___________________	________	______	________________	______________
___________________	________	______	________________	______________
___________________	________	______	________________	______________
___________________	________	______	________________	______________

If you are presently on probation or parole by another court; complete the following:

State – County: ____________________ ____

Probation Officer:___________________________________ Phone No.:____________________

Are you presently on bail or do you have any other outstanding criminal charges outside of Guadalupe County? ____

What are the charges and where?____

By signing/submitting this application, I have read or had read to me the Guadalupe County Veterans Treatment Court description and acknowledge that I will commit my time and effort to create in me behavioral and life change; if accepted. I have been truthful, to the best of my knowledge, with regard to all my answers in this application.

Please check the boxes that are completed & return the following documents:

- ☐ completed packet
- ☐ hand written essay/personal statement should include, but is not limited to the following:
  a. That you've accepted full responsibility for your wrongdoing;
  b. How your disorder is connected to the events you experienced during your military service;
  c. How your disorder is related to the criminal offense for which you are charged;
  d. Your role and contributions you made to the military;
  e. Why you should be afforded an opportunity to participate in the VTC;
  f. Any other information you want to have considered;
- ☐ copy of DD214
- ☐ copy of military identification card; if applicable
- ☐ VA release – as an attachment to this email
- ☐ VA Medical Card (White & Blue); if applicable

____ **Date:**________________

Signature

Please complete the attached VA Release:

- **Provide your full name, Last 4 SSN and DOB (on Page 1 &2);**
- **Sign and date (on Page 2); and**
- **On Page 2, please be sure you <u>initial</u> the two (2) boxes which pertain to Veterans Treatment Court in the section shown on the Sample below:**

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 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 <u>unless</u> 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 and that 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 disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

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): Upon completion or discharge from court program and associated supervision, which may go beyond completion of actual court program

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

FOR VA USE ONLY

TYPE AND EXTENT OF MATERIAL TO BE RELEASED

VJO will provide summary of progress via written, verbal, telephonic and secured email that is required by court for monitoring of patient's progress in treatment and compliance with legal conditions of VTC participation, inclusive of all relevant medical record information past, present and future. Information will include but is not limited to: diagnoses, relevant labs, prognosis and treatment, progress in treatment programming, developmental, social, financial and military data as relevant to court/legal circumstances to the designated court team and additional guests as permitted by the authorization. Information will be shared at regular intervals as needed by VJO to VTC to adequately assess progress and compliance. Information relevant to or impacting clinical treatment will be shared with VTC and VHA staff. Medical record information is subject to being discussed in an Open Docket Review.

DATE RELEASED	RELEASED BY:

VA FORM 10-5345, SEP 2018

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Sample Only

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)*
7400 Merton Minter Blvd; San Antonio, TX 78229
Any other VHA hospital or outpatient clinic where veteran is or has received treatment.

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
The Guadalupe County Veterans Treatment Court - 211 W. Court Street, Seguin, Texas 78155 - all affiliated individual agencies, attorneys, and court staff. Veteran agrees to additional guests/research investigators of the court ____yes _____no

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

☒ TREATMENT ☐ BENEFITS ☒ LEGAL ☐ EMPLOYMENT ☐ OTHER *(Please specify)* ____________

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)*: All drug/alcohol toxicology screens past and future
- ☐ DATE RANGE: ____________

☐ RADIOLOGY REPORTS *(Name & Date)*: ____________

☒ LIST OF ACTIVE MEDICATIONS: All medications past and future

☐ FLU VACCINATION *(Dose, Lot Number, Date & Location)*: ____________

☒ OTHER *(Describe)*: All medical record information deemed relevant by VJO past and future

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