

APPLICATION FOR TREATMENT COURT

Criminal Docket #: _____ OTN: _____

Criminal Charge(s): _____

Probation/Parole/Intermediate Punishment Revocation: YES NO

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

ANSWER ALL QUESTIONS

Name: _____ Age: _____ Date of Birth: _____

Address: _____

Phone (home): _____ Phone (cell): _____ S.S. #: _____

Place of Employment: _____ Medical Insurance: Yes No

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

Attorney name: _____ Phone: _____

Drug User: Yes No Drug Choice: _____ Length of Use: _____

Alcohol User: Yes No 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? Yes No

If Yes, list agency: _____

***Date of Formal Arraignment:** _____

VERIFICATION

I hereby verify that all answers contained herein are true and correct to the best of my information, knowledge and belief, and that false statements contained herein are made subject to the penalties of 18 Pa.C.S.A. § 4904, relating to unsworn falsification to authorities.

Signature of Applicant

Date

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

Application Sent to DA/VW

Application Sent to APO

Sent for Assessment

Assessment Completed

Application Sent to Judge

Application to Committee

DISTRICT ATTORNEY RECOMMENDATION

Recommended: Yes No

Not Recommended (Why?):

Comments:

District Attorney

Date

VICTIM RECOMMENDATION

Recommended: Yes No

Not Recommended (Why?):

Comments:

Victim/Witness Coordinator

Date

TREATMENT COURT COMMITTEE

Approved or Denied

COMMENTS:

Treatment Court Judge

Date