

Docket
Number(s) _____

Bucks County Drug Court Program Application

Please read each question carefully before answering. Failure to complete all required Drug Court forms and questionnaires accurately will delay the processing of your application. False or misleading information will be treated as a false statement subjecting you to exclusion from the Program. Drug Court needs the information requested to be able to review your needs and ensure that Drug Court could address these needs to better support your recovery.

Background Information:

Full Name: _____

Maiden Name /Alias(es): _____

Sex: Male Female

Home Address: _____

Street

Apartment Number

City

State

Zip Code

Phone Numbers: Home _____ Cell _____ Work _____

Social Security Number: _____

Date of Birth: _____ Age _____

Place of Birth: _____

City

County

State

Are you a citizen of the United States? YES NO

Race: White Black Asian American Indian or Alaskan Native
 Native Hawaiian or other Pacific Islander

Ethnicity: Hispanic or Latino Not Hispanic or Latino

Emergency Contact: _____ Relationship: _____

Address: _____

Phone Numbers: Home _____ Cell _____

Housing:

With whom do you currently reside or if incarcerated, with whom do you plan to reside?

Name	Relationship	Does he/she have a Criminal Record? If so, what are the charges?	Does this person use alcohol or other substances?

List your residences within the past ten (10) years:

Address	Roommate(s)

Education:

Highest level of education completed:

High School Grad GED College Grad Technical School

Check here if you need help obtaining a GED.

Name of High Schools attended: _____

Have you been suspended and/or expelled from school? If so, why? _____

What are your plans for education? _____

Do you speak, read and write the English language? YES NO

Have you ever been told by any teachers/school you needed to attend special classes? YES NO

If so, did you have an individual education plan (IEP) YES NO

Transportation:

What is your means of transportation? Own car Family Member Public transportation

Do you have a valid driver's license? YES NO

If YES, Operator's License Number: _____

If NO, has your license suspended and why? _____

Employment:

List all employment during the past three (3) years. Use additional sheets if necessary.

Employer	Address	Phone #	Supervisor	Dates

Do you need Job Training and/or help with your resume? YES NO

Financial Status:

Debts		Assets	
Item	Amount	Item	Amount

Marital Status/Children:

Single Married Divorced Separated Widowed

Other: _____

Are you presently involved in a relationship? YES NO

If YES, Name: _____ Date of Birth: _____

Address: _____

Is he/she in recovery? YES NO

Is he/she currently on probation or parole? YES NO

If YES, where? _____

For what crime(s)? _____

Do you have any children/How many/Ages _____

Do you have custody of your children? YES NO

If no, who has custody of your children? _____

Is there a custody order regarding your children? YES NO

If YES, in what County? _____

Is there/has there been Children and Youth involvement? YES NO

Name of CYS worker _____

Insurance Information:

What is the name of your Health Insurance Company? _____

Insurance Policy Number _____

Representation by Counsel:

Are you represented by counsel? YES NO

If YES, Counsel's Name: _____

Counsel's Address: _____

Counsel's Phone Number: _____

Prior Contact(s) with the Criminal Justice System:

Have you ever been arrested, charged, convicted/adjudicated, cited (including Vehicle Code violations) or held by any law-enforcement or juvenile authorities in the United States regardless of whether the citation or charge was dropped or dismissed or you were found not guilty or whether the record has been "sealed," expunged, or otherwise stricken from the court records on any occasion other than this arrest?

YES NO

If YES, complete the attached Criminal History & Incarceration Questionnaire on page 11

Do you have any prior convictions for violent offense(s)? YES NO

Violent offenses include, but are not limited to, the following offenses: Third Degree Murder, Voluntary Manslaughter, Aggravated Assault, Simple Assault, Terroristic Threats, Rape, Involuntary Deviate Sexual Intercourse, Aggravated Indecent Assault, Incest, Sexual Assault, Arson, Kidnapping, Burglary (of a structure adapted for overnight accommodation and at the time of the offense any person is present), and Robbery.

Have you ever been incarcerated, for any period of time for any reason? YES NO

If YES, complete the attached Criminal History & Incarceration Questionnaire on page 11.

Are you currently incarcerated? YES NO

If YES, date of detention: _____

Are you presently on probation or parole? YES NO

If YES, where and who is your Probation Officer (P.O.)?

State/County: _____

P.O.'s Name: _____

Are you presently on bail for a new case, including the one you are making application to Drug Court, or do you have any other outstanding criminal charges outside of Bucks County? YES NO

If Yes, please explain: _____

Medical History:

List any medical problems/diagnoses and treatment/medications you have had in the past 3 years:

Date	Problem/Diagnosis	Treatment	Medications

List any hospitalizations, including overdoses, in the past 3 years:

Date	Problem	Treatment	Medications

List any prescribed or over the counter medications for physical health issues that you are taking **now**:

Date last taken	Medication	Physical Health Issue	Name of prescribing doctor

List any prescribed medications for physical health issues that you have taken in the **past 3 years**:

Date last taken	Medication	Physical Health Issue	Name of prescribing doctor

Have you ever had lost of consciousness? Please include overdoses. YES NO

Please describe circumstances surrounding event: _____

Have you had a traumatic brain injury? YES NO

Please describe circumstances surrounding event: _____

Mental Health History:

Are you currently experiencing any mental health symptoms YES NO

If so, what are your symptoms? _____

Are you receiving treatment for these symptoms? YES NO

If yes, please complete the following:

Current Doctor/Treatment provider: _____

Date of last appointment attended: _____

What type of treatment (inpatient/outpatient): _____

Diagnosis: _____

List any mental health medications you are currently taking:

Current Medication	Dosage	Date Last Taken	Prescribing Doctor

Have you experienced any mental health symptoms in the past? YES NO

If so, what were your symptoms? _____

Have you received treatment in the past for these symptoms? YES NO

If yes, please complete the following regarding your previous mental health treatment history:

Date of Treatment	Provider	Specify inpatient/outpatient	Diagnosis	Medications

Substance Abuse History:

When was your first use of drugs or alcohol (age and specifics) and what led to your use?

What is your drug/alcohol use history? Use additional sheets if necessary.

Substance	Frequency	Amount	At What Age?	Date of Last Use

Are you currently in treatment for a Drug and Alcohol problem? YES NO

If yes, complete the following:

Doctor/Treatment provider: _____

Date of last appointment attended: _____

Level of Care: _____

Diagnosis: _____

Are you being prescribed methadone, suboxone or vivitrol? YES NO

If yes, what and when was last dose? _____

Have you tried methadone, suboxone or vivitrol in the past and if so, describe your experience with medication: _____

Have you engaged in Twelve Step meetings (AA, NA, etc.)? YES NO

If YES, do you have a sponsor? YES NO

Do you have a Home Group? YES NO

If YES, name of Home Group: _____

What is your longest period of sobriety and how did you maintain it? _____

Have you had or been in any treatment/hospitalizations/detox/rehab for drug and/or alcohol use?

YES NO If yes, please complete the following:

What is your substance abuse treatment history? Use additional sheets if necessary.

Facility	Level of care	Dates	Completed Successfully? How long were you abstinent

List individuals that are a positive influence in your life:

Name	Relationship	Address	Phone #

How would you describe your childhood? For example: healthy, chaotic, abusive. Is there anything about your childhood you feel important Drug Court should be aware of so proper treatment can be recommended? If so, please explain below.

Have you ever been asked to attend anger management therapy or experienced anger which led you to hurt someone, yourself, or destroy property? If so, explain circumstances.

Why are you applying for Drug Court?

By signing, I have read or had read to me the Drug Court Program description and acknowledge that I will commit my time and effort to create in me behavioral and life changes if accepted into Drug Court. I have been truthful, to the best of my knowledge, with regard to all my answers in this application, and if applicable, the attached Criminal History & Incarceration Questionnaire.

Signature

Date

Attorney Signature

Date

Attorney (Print Name)

Criminal History & Incarceration Questionnaire

List **ALL** prior convictions and prior periods of incarceration. Include any prior conviction(s) you have- even if you were not incarcerated on that case. Also, include any period of incarceration related to child/spousal support and Protection From Abuse (PFA) contempt matters. Use as many copies of this form as necessary.

1. Criminal Offense(s): _____
Docket Number(s): _____
Date(s): _____
Prison: _____

2. Criminal Offense(s): _____
Docket Number(s): _____
Date(s): _____
Prison: _____

3. Criminal Offense(s): _____
Docket Number(s): _____
Date(s): _____
Prison: _____

4. Criminal Offense(s): _____
Docket Number(s): _____
Date(s): _____
Prison: _____

5. Criminal Offense(s): _____
Docket Number(s): _____
Date(s): _____
Prison: _____

6. Criminal Offense(s): _____
Docket Number(s): _____
Date(s): _____
Prison: _____

7. Criminal Offense(s): _____
Docket Number(s): _____
Date(s): _____
Prison: _____

FOR OFFICIAL USE ONLY:

Date Application Submitted to Drug Court Coordinator:
Date Application Referred from Coordinator to District Attorney for Approval:
Date Application Referred from Coordinator to Treatment Coordinator for Approval:
Approved by District Attorney: <input type="checkbox"/> YES <input type="checkbox"/> NO Date:
If NO, explanation:
Recommended Sentence if Terminated/Fails to Complete Drug Court Program:
District Attorney's Agreement (if any) for Successful Completion of Drug Court Program:
Date Referred for Drug and Alcohol Assessment: Assessment Referred to:
Date of Assessment: Assessment Completed by:
Date/Time Scheduled to Observe Drug Court Program:
Date/Time Scheduled to Start Drug Court Program: