North Texas
Veterans' Court Program

INITIAL SCREENING FORM

YOU MUST SUBMIT A COPY OF YOUR DD214 WITH THIS APPLICATION

FULL NAME: _____ DATE: ____-____-_____

EMAIL ADDRESS: _____

NAME YOU WERE ARRESTED UNDER (IF DIFFERENT) _____

DOB: ____-____-_____ SSN: _____-_____-_____ SEX: _____

OFFENSE: _____ CASE #: _____ COURT: _____

COUNTY WHERE CHARGE IS: _____ ATTORNEY: _____

HOME ADDRESS: _____

CITY: _____ COUNTY: _____ STATE: _____ ZIP: _____

LENGTH OF RESIDENCY: _____

HOME PHONE: (_____)_____-_____ CELL: (_____)_____-_____

NAME(S) OF WHOM YOU LIVE WITH: _____

_____

ARE YOU A U.S. CITIZEN? _____ IF NOT, DO YOU HAVE LEGAL DOCUMENTS? _____

WHAT TYPE OF LEGAL DOCUMENTS DO YOU HAVE? _____

HOW LONG HAVE YOU LIVED IN THE UNITED STATES? _____

WHAT IS YOUR PRIMARY LANGUAGE? _____

DRIVER'S LICENSE # _____ ISSUING STATE: _____ EXPIRATION: _____

IF DRIVER'S LICENSE SUSPENDED, WHAT IS SUSPENSION DATE & LENGTH: _____

IF SUSPENDED, ARE YOU CURRENT ON SURCHARGES: YES OR NO

DO YOU **OWN** or **DRIVE** or **HAVE ACCESS TO A VEHICLE** ? _____

IF YOU DON'T HAVE ACCESS TO A VEHICLE, HOW DO YOU PLAN TO REPORT AND MAKE APPOINTMENTS? _____

CRIMINAL HISTORY

HAVE YOU EVER BEEN ARRESTED, PRIOR TO THIS INCIDENT: YES OR NO

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IF YES, LIST DATE, ARRESTING COUNTY, CHARGE, & CASE OUTCOME:

_____

_____

_____

EMPLOYMENT

EMPLOYER: _____ HOW LONG: _____

DO YOU WORK: **FULL TIME** or **PART TIME** or **TEMPORARY**

WHAT DO YOU DO? _____

EMPLOYER ADDRES: _____

PHONE: (_____) _____ – _____ OK TO CONTACT YOU AT WORK? _____

MONTHLY INCOME? _____

DO YOU RECEIVE ANY OTHER INCOME? _____ WHAT KIND? _____

HOW MUCH DO YOU RECEIVE? _____ HOW OFTEN? _____

DO YOU HAVE HEALTH INSURANCE? _____

MEDICARE_____ MEDICAID_____

IF YOU RECEIVE SSI / SSDI ARE YOU THE PAYEEE? _____

IF NOT WHO IS? _____

MILITARY

ARE / WERE YOU IN THE MILITARY? _____ BRANCH: _____

DISCHARGE DATE: _____ TYPE OF DISCHARGE: _____

IF DISCHARGED FOR MISCONDUCT, WHAT WAS THE MISCONDUCT: _____

WERE YOU DEPLOYED: YES OR NO IF YES, WHERE: _____

DO YOU HAVE COMBAT EXPERIENCE: YES OR NO

DO YOU HAVE A COMBAT-RELATED INJURY: YES OR NO

IF YES, PLEASE GIVE DETAILS: _____

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EDUCATION

DID YOU GRADUATE HIGH SCHOOL? _____ YEAR OF GRADUATION: _____

HIGHEST GRADE COMPLETED: _____ DO YOU HAVE A GED? _____ YEAR: _____

HIGH SCHOOL: _____

WERE YOU ENROLLED IN ANY SPECIAL EDUCATION CLASSES? _____

COLLEGE / UNIVERSITY: _____

CITY: _____ STATE: _____

ARE YOU CURRENTLY IN SCHOOL? _____ NUMBER OF HOURS: _____

DEPENDANTS

MARITAL STATUS: **SINGLE** or **MARRIED** or **DIVORCED** or **SEPARATED** or **WIDOWED**

HOW LONG: _____ SPOUSE'S NAME: _____

NUMBER OF CHILDREN: _____

DO YOU PROVIDE FINANCIAL SUPPORT FOR YOUR CHILDREN? _____

HOW MUCH DO YOU PROVIDE? _____ HOW OFTEN? _____

Name of Child:	**Live with you?** (Circle one)	**Gender** (Circle one)	**Date of Birth**
_____	Y / N	M / F	_____
_____	Y / N	M / F	_____
_____	Y / N	M / F	_____
_____	Y / N	M / F	_____
_____	Y / N	M / F	_____

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DRUG / ALCOHOL HISTORY

1. **NAME OF DRUG:** _____

   HOW DID YOU TAKE IT? **SMOKE** or **SNORT** or **DRINK** or **PILLS** or **SHOOT** or **OTHER** _____

   HOW OFTEN DID YOU USE IT? _____

   WHAT AMOUNT DID YOU USUALLY USE? _____ **$** _____

   AGE YOU FIRST USED: _____ DATE YOU LAST USED: _____

2. **NAME OF DRUG:** _____

   HOW DID YOU TAKE IT? **SMOKE** or **SNORT** or **DRINK** or **PILLS** or **SHOOT** or **OTHER** _____

   HOW OFTEN DID YOU USE IT? _____

   WHAT AMOUNT DID YOU USUALLY USE? _____ **$** _____

   AGE YOU FIRST USED: _____ DATE YOU LAST USED: _____

3. **NAME OF DRUG:** _____

   HOW DID YOU TAKE IT? **SMOKE** or **SNORT** or **DRINK** or **PILLS** or **SHOOT** or **OTHER** _____

   HOW OFTEN DID YOU USE IT? _____

   WHAT AMOUNT DID YOU USUALLY USE? _____ **$** _____

   AGE YOU FIRST USED: _____ DATE YOU LAST USED: _____

4. **NAME OF DRUG:** _____

   HOW DID YOU TAKE IT? **SMOKE** or **SNORT** or **DRINK** or **PILLS** or **SHOOT** or **OTHER** _____

   HOW OFTEN DID YOU USE IT? _____

   WHAT AMOUNT DID YOU USUALLY USE? _____ **$** _____

   AGE YOU FIRST USED: _____ DATE YOU LAST USED: _____

MEDICAL/PSYCHIATRIC HISTORY

HAVE YOU HAD PRIOR TREATMENT FOR SUBSTANCE /ABUSE OR A MENTALL ILLNESS?

Dates of Admission	Name of Hospital	City	State	Reason for Admission

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CURRENT MEDICAL DIAGNOSIS: _____

DID YOU SUFFER A COMBAT INJURY? YES NO IF YES: WHEN, WHERE & DETAILS?

_____

CURRENT PSYCHIATRIC DIAGNOSIS _____

_____

ARE YOU CURRENTLY UNDER A DOCTOR'S CARE? YES NO

NAME OF DOCTOR: _____ REASON FOR SEEING: _____

NAME OF DOCTOR: _____ REASON FOR SEEING: _____

NAME OF DOCTOR: _____ REASON FOR SEEING: _____

ARE YOU CURRENTLY TAKING MEDICATION(S)? _____

MEDICATION: _____ PRESCRIBING DOCTOR: _____

MEDICATION: _____ PRESCRIBING DOCTOR: _____

MEDICATION: _____ PRESCRIBING DOCTOR: _____

MEDICATION: _____ PRESCRIBING DOCTOR: _____

MEDICATION: _____ PRESCRIBING DOCTOR: _____

REFERENCES *(family / friends)*

NAME: _____ RELATIONSHIP TO YOU? _____

ADDRESS: _____

CITY: _____ COUNTY: _____ STATE: _____ ZIP: _____

PHONE: (_____)_____–_____ PHONE: (_____)_____–_____

NAME: _____ RELATIONSHIP TO YOU? _____

ADDRESS: _____

CITY: _____ COUNTY: _____ STATE: _____ ZIP: _____

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PHONE: (_____)_____-_____ PHONE: (_____)_____-_____

ATTORNEY INFORMATION

NAME: _____

PHONE: (_____)_____-_____ FAX: (_____)_____-_____

TO OBTAIN A COPY OF YOUR DD214 FROM THE GOVERNMENT, GO TO:

HTTP://WWW.ARCHIVES.GOV/VETERANS/MILITARY-SERVICE-RECORDS/

I HEREBY ACKNOWLEDGE AND CERTIFY THAT I HAVE ANSWERED ALL QUESTIONS ABOVE AND THAT THE INFORMATION IS TRUE AND CORRECT.

_____ _____

Applicant Signature ***Date***

This program is supported by a grant from the Texas Veterans Commission *Fund for Veterans' Assistance*. The *Fund for Veterans' Assistance* provides grants to organizations serving veterans and their families.

www.tvc.state.tx.us

North Texas Veterans Court Program

INFORMED CONSENT FOR INTERVIEW AND PERMISSION TO RELEASE INFORMATION

The goals of the North Texas Veterans Court Program are consistent with Texas Health and Safety Code 617.001, to provide diversion of Justice-Involved Veterans whom combat service resulted in a brain injury, mental illness, or mental disorder, including post-traumatic stress disorder. The Veterans Court Program will identify eligible veterans and link them to needed services as an alternative to subjecting those defendants to the traditional criminal justice system. By successfully completing the program, eligible charges will be dismissed and eligible for expunction.

I, the undersigned, understand that I am being interviewed by a member of the North Texas Veterans Court Program to help determine if I preliminarily meet the clinical criteria for admission into the Veterans Court Program. I understand that this interview does not mean I am accepted into the program and as such, I am required to follow all current bonds, pretrial, or court ordered conditions.

I hereby consent to the interview as described above and give my permission for information gathered during this interview, and other sources to be shared with the members of the Veterans Court Program Team which includes but is not limited to: other mental health professionals for consultation and training purposes, mentor coordinator, criminal defense attorneys, prosecutors and other criminal justice/court staff and personnel as outlined in Texas Health and Safety Code Sec. 611.004. By signing this document, I understand I am waiving my legal rights to confidentiality to allow judicial efficiency due to my current pending case(s).

I agree to meet with my attorney to discuss the conditions of the program to ensure I am making an informed decision to enter the program before I sign any required legal documents. I understand that admission to this program is voluntary and that the final approval for admission will be determined by a representative of the District Attorney's Office and the Judge of the North Texas Veterans Court Program.

Applicant Signature_____

Printed Name _____

Witness _____

Date _____

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

PRIVACY ACT INFORMATION: 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. VHA 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" and in accordance with the VHA Notice of Privacy Practices. VA may also use this information to identify Veterans and persons 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)*

NORTH TEXAS VA HEALTH CARE SYSTEM
4500 S. LANCASTER
DALLAS, TX 75216

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

VBA; VSOs; correctional staff; community supervision officers; jail/court mental health diversion staff; Veterans' Court to include: judge, staff, team, guests, and all officers of the court.

VETERAN'S REQUEST

I request and authorize Department of Veterans Affairs to release the information specified below to the organization, or individual named on this request. I understand that the information to be released includes information regarding the following condition(s):

- [X] DRUG ABUSE
- [X] SICKLE CELL ANEMIA
- [X] ALCOHOLISM OR ALCOHOL ABUSE
- [X] TESTING FOR OR INFECTION WITH HUMAN IMMUNODEFICIENCY VIRUS *(HIV)*

DESCRIPTION OF INFORMATION REQUESTED

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

- [X] HEALTH SUMMARY *(Prior 2 Years)*
- [ ] INPATIENT DISCHARGE SUMMARY *(Dates)*: _____
- [X] PROGRESS NOTES:
  - [X] SPECIFIC CLINICS *(Name & Date Range)*: All mental health,medical,& drug/alcohol abuse notes
  - [ ] SPECIFIC PROVIDERS *(Name & Date Range)*: _____
  - [ ] DATE RANGE: _____
- [ ] OPERATIVE/CLINICAL PROCEDURES *(Name & Date)*: _____
- [X] LAB RESULTS:
  - [X] SPECIFIC TESTS *(Name & Date)*: All HIV/sickle cell treatment,medications,drug/alcohol labs
  - [ ] DATE RANGE: _____
- [ ] RADIOLOGY REPORTS *(Name & Date)*: _____
- [X] LIST OF ACTIVE MEDICATIONS _____
- [X] OTHER *(Describe)*: Appointment information, problem list

PURPOSE(S) OR NEED

Information is to be used by the individual for:

- [X] TREATMENT
- [X] BENEFITS
- [X] LEGAL
- [X] OTHER *(Specify below)*

Assist Vet with continuity of care; provide court with current treatment status of Vet

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

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.

☐ UPON SATISFACTION OF THE NEED FOR DISCLOSURE

☐ ON _____ *(enter a future date other than date signed by patient)*

☒ UNDER THE FOLLOWING CONDITION(S): 1. Written revocation submitted to VA staff; 2. Written verifcation from court that VA recs are no longer required; 3. Upon court completion

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 RELEASED

DATE RELEASED	RELEASED BY: