Approved/Denied/Referred to other Treatment Court Case # _____

OTN_____ Probation/Parole Violation: YES/NO

APPLICATION FOR TREATMENT COURT

Please check the appropriate court you are applying for:

Mental Health 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 current driver's license? Y or N If not, why? _____

Driver's License Number/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/Officer: _____ 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: _____

Have you applied for or participated in any treatment court programs in this or any other county? _____

If yes, what county(ies)? _____

Are you a Veteran? Yes _____ No_____

Signature: _____ Date: _____

Referral Source Signature: _____ Date: _____

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

_____	_____	_____
Application Rec'd	Sent to DA	Sent for Assessment
_____	_____	_____
Police Liaison	Assessment Compl.	To Committee

DISTRICT ATTORNEY ELIGIBILITY

RECOMMENDED:

NOT RECOMMENDED:
(WHY?)

COMMENTS:

Lycoming County Probation Intake Information Sheet

Instructions: Do not leave any sections blank. If something does not apply, put N/A in that section.

PERSONAL DEMOGRAPHICS:

NAME: _____
LAST FIRST MIDDLE

ALIAS: _____
LAST FIRST MIDDLE

DATE OF BIRTH: _____

SOCIAL SECURITY NUMBER: _____

SEX: ☐ MALE ☐ FEMALE ☐ OTHER

EMAIL ADDRESS: _____

PLACE OF BIRTH: _____
COUNTRY CITY, STATE

RELIGION: _____

PRIMARY LANGUAGE : _____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ COMMON LAW

US CITIZEN: ☐ YES ☐ NO

PHYSICAL INFORMATION

HEIGHT	WEIGHT	BODY BUILD	EYE COLOR	HAIR COLOR

RACE: ☐ WHITE ☐ BLACK ☐ HISPANIC ☐ ASIAN ☐ AMERICAN INDIAN ☐ OTHER

ETHNICITY: ☐ HISPANIC ☐ NON HISPANIC ☐ UNKNOWN

SCARS/MARKS/TATTOOS: (LIST DESCRIPTION AND LOCATION) _____

_____

_____

ADDRESS AND PHONE NUMBER

PHYSICAL RESIDENTIAL ADDRESS

HOUSE TYPE: _____

STREET AND NUMBER: _____

APARTMENT NUMBER: _____

CITY: _____

STATE: _____

ZIP CODE: _____

COUNTY: _____

TOWNSHIP/BOROUGH: _____

TIME AT PRESENT ADDRESS: _____

ANY PETS? (IF YES, LIST TYPE AND QUANTITY): _____

MAILING ADDRESS

SAME AS PHYSICAL ADDRESS? ☐ YES ☐ NO (IF NO, THEN FILL OUT BELOW)

HOUSE TYPE: _____

STREET AND NUMBER: _____

APARTMENT NUMBER: _____

CITY: _____

STATE: _____

ZIP CODE: _____

COUNTY: _____

TOWNSHIP/BOROUGH: _____

PHONE NUMBERS

MOBILE/CELL PHONE: _____

HOME PHONE: _____

OTHER PHONE: _____

HEALTH/MEDICAL

SERIOUS MEDICAL CONDITIONS? ☐ YES (EXPLAIN BELOW) ☐ NO

LIST HERE: _____

MENTAL HEALTH ISSUES? ☐ YES (EXPLAIN BELOW) ☐ NO

LIST HERE: _____

CURRENT PRESCRIBED MEDICATIONS? ☐ YES (EXPLAIN BELOW) ☐ NO

LIST HERE: _____

_____

EMERGENCY CONTACTS:

CONTACT 1

NAME: _____
LAST FIRST MIDDLE

DATE OF BIRTH: _____

STREET AND NUMBER: _____

APARTMENT NUMBER: _____

CITY: _____

STATE: _____

ZIP CODE: _____

COUNTY: _____

PHONE NUMBER: _____

RELATIONSHIP TO YOU: _____

CONTACT 2

NAME: _____
LAST FIRST MIDDLE

DATE OF BIRTH: _____

STREET AND NUMBER: _____

APARTMENT NUMBER: _____

CITY: _____

STATE: _____

ZIP CODE: _____

COUNTY: _____

PHONE NUMBER: _____

RELATIONSHIP TO YOU _____

SUBSTANCE ABUSE

DO YOU DRINK ALCOHOL? ☐ YES (IF YES, FILL OUT BELOW) ☐ NO

IF YES, TYPE, AMOUNT AND HOW OFTEN: _____

DO YOU CONSUME ILLEGAL DRUGS? ☐ YES (IF YES, FILL OUT BELOW) ☐ NO

IF YES, TYPE, AMOUNT AND HOW OFTEN: _____

DRUGS YOU'VE TRIED IN YOUR ENTIRE LIFE: _____

CRIMINAL HISTORY

EVER CONVICTED OF SEXUAL OFFENSE? ☐ YES (IF CHECKED FILL OUT INFORMATION BELOW) ☐ NO

LIST OFFENSE AND YEAR COMMITTED: _____

_____

MEGAN'S LAW OFFENDER? ☐ YES ☐ NO

IF YES: ☐ TIER 1 ☐ TIER 2 ☐ TIER 3 ☐ OTHER

DEEMED A SEXUALLY VIOLENT PREDATOR? ☐ YES ☐ NO

EDUCATION

HIGH SCHOOL:

NAME OF HIGH SCHOOL ATTENDED: _____

DID YOU GRADUATE HIGH SCHOOL? ☐ YES _____ If Yes, Year Completed ☐ NO (IF NO, FILL OUT BELOW)

HIGHEST GRADE COMPLETED: _____

DID YOU OBTAIN YOUR GED ☐ YES ☐ NO

HIGHER EDUCATION/TRADE SCHOOL

DID YOU ATTEND COLLEGE OR TRADE SCHOOL? ☐ YES (IF YES, FILL OUT BELOW) ☐ NO

NAME OF COLLEGE OR TRADE SCHOOL ATTENDED: _____

DID YOU GRADUATE? ☐ YES ☐ NO

IF YES, HIGHEST COMPLETED:

☐ CERTIFICATE	☐ ASSOCIATES	☐ BACHELORS	☐ MASTERS	☐ DOCTORATE

YEAR COMPLETED: _____

IF NO, HIGHEST LEVEL COMPLETED: _____

EMPLOYMENT

LEGALLY ABLE TO WORK? ☐ YES ☐ NO

EMPLOYMENT STATUS	☐ FULL TIME	☐ PART TIME	☐ DISABLED	☐ RETIRED	☐ STUDENT	☐ UNEMPLOYED

EMPLOYER NAME: _____

EMPLOYER ADDRESS: _____

EMPLOYER PHONE: _____

POSITION HELD: _____

LENGTH OF EMPLOYMENT: _____

AVERAGE INCOME/WEEK: _____

IF UNEMPLOYED, HOW LONG? _____

IF UNEMPLOYED, WHY? _____

GANGS

HAVE YOU EVER BEEN IN A GANG? ☐ YES (IF YES, FILL OUT BELOW) ☐ NO

LIST GANG AFFILIATION: _____

MILITARY SERVICE

EVER SERVE IN MILITARY ☐ YES (IF YES, FILL OUT BELOW) ☐ NO

BRANCH SERVED: _____

YEAR DISCHARGED: _____

DISCHARGE STATUS ☐ HONORABLE ☐ OTHER THAN HONORABLE/DISHONORABLE

DRIVERS LICENSE/ ID

DO YOU HAVE A DRIVERS LICENSE? ☐ YES (IF YES, FILL OUT BELOW) ☐ NO

DRIVERS LICENSE NUMBER/STATE: _____

IS YOUR LICENSE VALID ☐ YES ☐ NO

IF NO, WHY NOT? _____

DO YOU HAVE A STATE ID? ☐ YES (IF YES, FILL OUT BELOW) ☐ NO

STATE ID NUMBER/STATE: _____

VEHICLE INFORMATION

DO YOU OWN A VEHICLE? ☐ YES (IF YES, FILL OUT BELOW) ☐ NO

MAKE: _____

MODEL: _____

YEAR: _____

COLOR: _____

LICENSE PLATE NUMBER: _____

WEAPONS:

ARE YOU PERMITTED TO POSSESS FIREARMS? ☐ YES ☐ NO

DO YOU HAVE FIREARMS OR OTHER DEADLY WEAPONS IN YOUR HOME? ☐ YES ☐ NO

ARE YOU TRAINED IN HAND-TO-HAND COMBAT? ☐ YES ☐ NO

OTHER INCOME/ENTITLEMENTS

DO YOU RECEIVE UNEMPLOYMENT, DISABILITY, OR RETIREMENT	☐ YES (IF YES, FILL OUT BELOW)	☐ NO

SPECIFY TYPE AND AMOUNT RECEIVED: _____

DO YOU RECEIVE FOOD STAMPS, WELFARE, OR OTHER PUBLIC ASSISTANCE?	☐ YES (IF YES, FILL OUT BELOW)	☐ NO

SPECIFY TYPE AND AMOUNT RECEIVED: _____

LYCOMING-CLINTON MENTAL HEALTH/INTELLECTUAL DISABILITY PROGRAM
AUTHORIZATION FOR RELEASE OF INFORMATION

[ ] 200 East Street
Sharwell Building
Williamsport, PA 17701

[x] 8 North Grove St, Suite A
Lock Haven, PA 17745

I authorize the use/disclosure of information about me as described below:

Name: _____ Birthdate: _____ Social Security #: _____

Address: _____ City: _____ State: PA Zip: _____

Day Phone:

PROVIDER/REQUESTOR: I AUTHORIZE LYCOMING-CLINTON MH/ID PROGRAM TO:

[ ] RELEASE TO: **OR** **[x] RECEIVE FROM:**

Provider/Requestor _____

Name Address

INFORMATION TO BE DISCLOSED: Dates of Treatment from _____ to _____

[ ] Psychological Evaluation	[ ] Psycosocial History	[ ] Psychiatric Evaluation
[ ] Social History	[x] Medical History/Records	[ ] School Records
[ ] Drug and Alcohol History	[ ] Progress Reports	[ ] Discharge Summary
[ ] Financial Benefits/Records	[ ] DPA Benefits	[ ] Social Security Benefits
[ ] Insurance /Pension	[ ] VA Benefits	[ ] Other: _____

SPECIAL AUTHORIZATION: My evaluation, diagnosis, and/or treatment may be released to the requestor noted above as indicated by my initials next to the information to be released.

[ ] Behavioral Health [ ] HIV/AIDS [ ] Alcohol and/or drug abuse or dependence

REASON FOR THE RELEASE:

[ ] Insurance	[ ] Legal	[x] Continued Care
[ ] Personal	[ ] Other Specified:	

REVOCATION:

I understand that I may revoke this authorization in writing at any time by sending written notification to the provider. I understand that any such revocation is not effective to the extent that action has been taken in reliance on this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by state or federal law.

I understand that providing authorization for the requested use or disclosure is not a condition of my treatment, payment enrollment in a health plan or eligibility for benefits except (1) if my treatment is related to research; or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third part.

This authorization shall be in force and effect until_____. (Note: must specify (a) an expiration date; or (b) an expiration event that relates to the individual or the purpose of the use or disclosure. The statement "end of research study," "none," or similar language is sufficient if the authorization is for a use or disclosure of protected health information for research, including for the creation and maintenance of a research database or research repository).

AUTHORIZATION:

I authorize the provider to release the information above to the requestor.

Patient's Signature: _____ Date: _____

Witness's Signature: _____ Date: _____

IF PATIENT IS UNABLE TO CONSENT BECAUSE OF AGE OR PHYSICAL CONDITION, PLEASE COMPLETE ONE OF THE FOLLOWING:

Patient (is a minor____ years of age) OR (is unable to give consent because_____

Patient Representative's Signature_____ Relationship_____Date:_____

This information has been disclosed to you from records whose CONFIDENTIALITY is protected by State Law. Pennsylvania State Regulations prohibit you from making any further disclosure of this information without the prior written consent of person with respect to whom it pertains.

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:

_X_ Whether the client is or is not in treatment
_X_ The nature of the project
_X_ Whether or not the client has relapsed
_X_ 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
_X_ To monitor the provision of ongoing treatment
_X_ 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 verbally or in writing 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

_____
Specify date, event or condition upon which release will expire.

Revised 10/5/23