

STATE OF MICHIGAN COUNTY OF MACOMB 16 TH JUDICIAL COURT	16 TH JUDICIAL CIRCUIT TREATMENT COURT APPLICATION	ALL CIRCUIT COURT CASE #S:
		JUDGE:

PEOPLE OF THE STATE OF MICHIGAN V.	Defendant:
	Defense Counsel Name:
	Defense Counsel Phone Number:

Next Court Date: _____

Candidate is: <input type="checkbox"/> Incarcerated <input type="checkbox"/> On Bond	
Current Case(s) Charge(s):	
Sentencing Guidelines:	
Is there a victim in this matter? <input type="checkbox"/> Yes <input type="checkbox"/> No	Victim's relationship to the defendant:
Have you ever participated in a Drug Court, Sobriety Court, Mental Health Court or Veteran's Court before? <input type="checkbox"/> Yes <input type="checkbox"/> No	
When did you participate?	Where did you participate?
List all open case(s) in other courts (including any outstanding warrants)	
Do you have any assaultive charges or CSC charges on your criminal history: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list charges:	

DEMOGRAPHIC INFORMATION (All Fields Required):

GENDER: Male Female

Address:	DOB:	Cell Phone:
City:	Zip:	Email address:

CURRENT LIVING SITUATION:

- Own Home/Apartment Sober Living Other _____
 With a Friend/Relative Homeless

Are you a US Citizen? Yes No Last 4 of Social Security Number: _____

MILITARY:

Have you ever served in the United States Military? <input type="checkbox"/> Yes <input type="checkbox"/> No	Service Start Date:
	Service End Date:

Branch of Service:

- Air Force Coast Guard Navy
 Army Marines Reserves

Combat Deployment? <input type="checkbox"/> Yes <input type="checkbox"/> No	Location:
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Current Military Status:

- Active General Under Other Than Honorable Conditions
 Honorable Discharge Dishonorable or Bad Conduct Discharge:
 General Under Honorable Conditions

Are you eligible for VA benefits/services? Yes No

PHYSICAL HEALTH:

Do you have any current medical conditions? Yes No

Please describe: _____

Are you able to participate in our program with these conditions? Yes No

Do you have any physical limitation(s)? Yes No If yes: _____

If yes, are you able to participate in our program with this limitation(s)? Yes No

Do you have Medicaid coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have any other health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Are you currently taking ANY medications? Yes No Please describe all medications including over the counter medications and herbal supplements: _____

MENTAL HEALTH:

Have you ever had a mental health diagnosis? Yes No If yes, please describe:

Have you ever attended treatment for a mental health issue? Yes No If yes, please describe where and when: _____

Are you currently taking ANY medications for mental health issues? Yes No If yes, please described ALL medications including over the counter and herbal supplements:

Do you have a guardian? Yes No

If Yes, Name or Agency _____ Phone: _____

SUBSTANCE ABUSE:

Have you ever abused alcohol or other drugs? Yes No If yes, what substances (check all that apply):

- | | | |
|---|---|---|
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Crack Cocaine | <input type="checkbox"/> Methadone |
| <input type="checkbox"/> Amphetamines | <input type="checkbox"/> Heroin | <input type="checkbox"/> Suboxone |
| <input type="checkbox"/> Benzodiazepine | <input type="checkbox"/> Opiate (Other) | <input type="checkbox"/> Methamphetamines |
| <input type="checkbox"/> Cocaine | <input type="checkbox"/> Marijuana | <input type="checkbox"/> Other _____ |

Have you ever abused prescription medications? Yes No

If yes, describe: _____

How long have you abused alcohol or other drugs? _____

Do you acknowledge that you abuse or are dependent on alcohol or drugs? Yes No

ABILITY TO MEANINGFULLY PARTICIPATE:

Do you have reliable transportation or bus availability to attend any or all of the following: mental health or substance abuse treatment, alcohol/drug testing, probation reporting, up to weekly reports to the Court, case management sessions with the coordinator and regular attendance at a self-help support program?

Yes No

What are the most important areas you would like to address or improve on in a treatment court setting?

ACKNOWLEDGEMENT:

I understand that this information is intended to be used for eligibility into one of the Specialty Court Treatment Courts. It does not guarantee my acceptance into the program. Furthermore, I understand that the demographic information contained on this form (including ethnicity and race) will be used for statistical reporting purposes only and will not affect my eligibility.

Defendant's Signature:	Defense Counsel Signature:
Approved by Judge: (signature here or entered in CourtView docket)	Date of Application:

This application will be considered for all specialty court programs at the 16th Judicial Circuit Court. If the defendant is not eligible for a Circuit Court program and the Judge approves, this application could be forwarded to an appropriate District Court program for consideration there.

RETURN COMPLETED FORM TO THE SPECIALTY COURT DEPARTMENT

In person: 6th floor, Court building

Fax: (586) 783-8179

Email: treatmentcourts@macombgov.org