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: ________

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: ________

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? ______________________________

EMPLOYMENT

EMPLOYER: ______________________________ HOW LONG: ____________

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

WHAT DO YOU DO? ______________________________

EMPLOYER ADDRES: ______________________________

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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: ___________________________

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

IF YES, PLEASE GIVE DETAILS: ____

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: ____________________________________

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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	____________

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: ________________________________

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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

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: ________________

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REFERENCES *(family / friends)*

NAME: ______________________ RELATIONSHIP TO YOU? ____________

ADDRESS: ____

CITY: ____________ COUNTY: __________ STATE: _____ ZIP: ________

PHONE: (________)________–__________ PHONE: (________)________–__________

NAME: ______________________ RELATIONSHIP TO YOU? ____________

ADDRESS: ____

CITY: ____________ COUNTY: __________ STATE: _____ ZIP: ________

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 ____________________

OMB Number: 2900-0260
Estimated Burden: 2 minutes

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE MEDICAL RECORDS OR HEALTH INFORMATION

Privacy Act and Paperwork Reduction 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 Social Security Number (SSN) (the SSN will be used to locate records for release) is not furnished completely and accurately, Department of Veterans Affairs 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. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act systems of records notices identified as 24VA10P2 "Patient Medical Record - VA" and in accordance with the Notice of Privacy Practices. You do not have to provide the information to VA, but if you don't, VA will be unable to process your request and serve your medical needs. Failure to furnish the information will not have any affect on any other benefits to which you may be entitled. If you provide VA your Social Security Number, VA will use it to administer your VA benefits. 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. The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 2 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

ENTER BELOW THE PATIENT'S NAME AND SOCIAL SECURITY NUMBER IF THE PATIENT DATA CARD IMPRINT IS NOT USED.

TO: DEPARTMENT OF VETERANS AFFAIRS (Print or type name and address of health care facility)

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

PATIENT NAME (Last, First, Middle Initial)

SOCIAL SECURITY NUMBER

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 Judge, staff, team; 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):

☒ DRUG ABUSE ☒ ALCOHOLISM OR ALCOHOL ABUSE ☒ TESTING FOR OR INFECTION WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV) ☒ SICKLE CELL ANEMIA

INFORMATION REQUESTED (Check applicable box(es) and state the extent or nature of the information to be disclosed, giving the dates or approximate dates covered by each)

☒ COPY OF HOSPITAL SUMMARY ☒ COPY OF OUTPATIENT TREATMENT NOTE(S) ☒ OTHER (Specify)

all mental health and medical and drug/alcohol abuse progress notes____
HIV/sickle cell treatment,medications,drug/alcohol test results_____
appointment information, lab results____

PURPOSE(S) OR NEED FOR WHICH THE INFORMATION IS TO BE USED BY INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

To assist veteran with continuity of care; provide treatment court with history; provide court or probation/parole with current status reports on Veteran adhering to rules of treatment, probation or parole. Authorizes release of records created after the date of signature of this authorization. Information may be

NOTE: ADDITIONAL ITEMS OF INFORMATION DESIRED MAY BE LISTED ON THE BACK OF THIS FORM

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 the records. Redisclosure of my medical records by those receiving the above authorized information may be accomplished without my further written authorization and may no longer be protected. Without my express revocation, the authorization will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on ______ (date supplied by patient); (3) under the following condition(s):

1. written revocation from veteran submitted to VA staff ______
2. written verification from courts/parole/probation offices to VA staff that VA records are no longer required _____
3. upon completion of a formal diversion court program (Veterans or Mental Health Court

I understand that the VA health care practitioner'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.

DATE (mm/dd/yyyy)	SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO SIGN FOR PATIENT (Attach authority to sign, e.g., POA)

FOR VA USE ONLY

IMPRINT PATIENT DATA CARD (or enter Name, Address, Social Security Number)	TYPE AND EXTENT OF MATERIAL RELEASED	
	DATE RELEASED	RELEASED BY

VA FORM JUL 2013 **10-5345** USE EXISTING STOCK OF VA FORM 10-5345, DATED MAY 2005.