VETERANS COURT

This application is to be picked up and filled out with your **ATTORNEY PRESENT.**

1. Please be sure to submit a copy of your dd-214 with this application.

2. Please initial all required spaces on the Release Of Information forms.

3. Please make sure Attorneys information including email is on the application and also they have signed the document as your legal representative.

Thank you for applying to the Veterans Court, if any of these items are missed and not filled out your application **WILL NOT BE PROCESSED.** If you have any questions please contact Veterans Program Coordinator Sheria West 214 653 5935.

Dallas County Veterans Treatment Court Program Referral Form

The Veterans' Court Program is a special program within the Dallas County Criminal Justice System. It is a pre-adjudication supervision program for Veterans that are arrested in Dallas County, who have served our Country in the U.S. Military Services, including the Army, Marine Corp, Navy, Air Force, Coast Guard, or their corresponding Reserve or Guard branches. Combat service is no longer a requirement for participation, and veterans with other than Honorable discharges will be evaluated on a case-by-case basis.

To participate:

The Veteran must have a discharge that allows them to receive VA services or currently be on Active Duty

- Current offense must also be one where a prosecutor would normally consider for community supervision recommendation
- Felony and Misdemeanor DWI's will be considered
- Mental health assessor must find:
  - A. A mental disease or defect
  - B. That the mental disease or defect contributed, in whole or in part, to the charged offense
- The Veteran must be willing to undergo the prescribed treatment of the Veterans court team in order to address the mental disease or defect that led to the criminal charge
- The Veteran grants permission to the Veterans Court to have access to the Veteran's treatment records and, as necessary, to the Veteran's military records in order to provide treatment with the goal of dismissing pending criminal charges.
- YOUR APPLICATION WILL BE PROCESSED MUCH MORE QUICKLY IF YOUR CLIENT ATTACHES A COPY OF HIS/HER DD-214

To apply:

Please drop off completed referral form to Mrs. Sheria West, Veterans Program Specialty Coordinator in CDC 4, on the 6th Floor of Frank Crowley. If you have, questions call 214-653-5935. You may drop your application off in the Vet Court Box located on the wall above the applications. **IS YOUR CLIENT IN JAIL?** Circle: YES or NO

Veteran Offender Information-*REQUIRED INFORMATION

Case #_____ **Charge/Court**_____

Case #_____ **Charge/Court**_____

Case #_____ **Charge/Court**_____

Name: _____ DOB# _____

SS #: _____ Driver License No. _____ DL State of Issuance: _____

Address at the time of arrest: _____

Date of referral: _____ Referred By: _____

Attorney: _____ Contact Number: _____

(REQUIRED) ATTORNEY EMAIL:_____

DD-214 ATTACHED Y N IF NOT ATTACHED PLEASE EMAIL A COPY TO **SMATHIS@DALLASCOUNTY.ORG**

Branch of Service_____ Discharge Type_____ Combat Service_____

Veteran's contact number & address_____

Alternate contact name & number_____

Date of referral:_____ Referred by:_____

*****Dallas County Veterans Treatment Court Program Staff Only******

DD 214/Requested:_____ **DD214/VA eligibility confirmation**_____

ADA Background CHECK REQUESTED:_____ **ADA Background Check/Approval:**_____

Application copied and delivered to ATRS to be scheduled:_____

Dallas County Veterans Treatment Court Program
Application

Judge Dominique Collins
Criminal District Court #4
133 N. Riverfront Blvd.
Dallas, Texas 75207

Mental Health Information (If known)

Current diagnosis: _____PTSD ____ TBI____ Bipolar Disorder ____ Major Depressive Disorder _____ Anxiety ____Schizoaffective Disorder ____ Schizophrenia ____ other _____

Additional comments (Other Pending cases): _____

GENERAL INFORMATION

FULL NAME: _____ DATE_____

NAME YOU WERE ARRESTED UNDER (IF DIFFERENT) _____

DOB: _____-_____-_____ SSN: _____-____-_____ RACE: _____ ETHINICITY_____ SEX: _____

ADDRESS: _____ CITY_____STATE_____ZIP_____

COUNTY: _____ LENGTH OF RESIDENCY: _____

ADDRESS (DATE OF ARREST)_____ CITY_____ STATE_____ZIP_____

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

NAME(S) OF WHOM YOU LIVED WITH: _____

_____

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

PLACE OF BIRTH_____ PRIMARY LANGUAGE: _____

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

DO YOU: _____OWN _____DRIVE _____HAVE ACCESS TO A VEHICLE _____PUBLIC TRANSPORTATION

AUTOMOBILE INOF: MAKE_____MODEL:_____COLOR:_____ YEAR_____

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

_____

EMPLOYMENT

____FULL-TIME ____PART TIME ____TEMPORARY _____SEASONAL

EMPLOYER: _____

ADDRESS: _____ PHONE: (_____) _____-_____

HOW LONG: _____ EMPLOYMENT START DATE: _____

TYPE OF WORK: _____ SCHEDULE _____

TOTAL MONTHLY INCOME: _____ HOURLY PAY: _____

LIST ALL SOURCES: ____EMPLOYMENT____ UNEMPLOYMENT____ GI BILL_____ SSI/SSDI_____ RETIREMENT____

____ VA DISABILITY ____ VA PENSION ____ OTHER

HEALTH INSURANCE: ____ PRIVATE ____ MEDICARE ____ MEDICAID _____NONE

MILITARY

YEARS OF SERVICE: _____ TO _____ BRANCH: _____

MOS: _____ STATIONED: _____

DISCHARGE RANK: _____ DISCHARGE DATE: _____ DISCHARGE TYPE: _____

COMBAT EXPOSURE _____ HOSTILE OR IMINIENT DANGER PAY _____

LIST ANY DEPOYMENTS:

DATE: _____ LOCATION: _____

DATE: _____ LOCATION: _____

DATE: _____ LOCATION: _____

WHAT IF ANY CAMPAIGN MEDALS DID YOU RECEIVE: _____

EDUCATION

HIGHEST GRADE COMPLETED _____ YEAR GRADUATED: _____

EARNED A GED _____ YEAR _____

NAME OF HIGH SCHOOL/STATE: _____

CURRENTLY ENROLLED SCHOOL: _____

NAME OF COLLEGE/UNIVERSITY/TRADE SCHOOL: _____

FULL TIME/PART-TIME ONSITE _____ REMOTE LEARNING: _____

DEPENDENTS

MARITAL STATUS: _____SINGLE _____MARRIED _____DIVORCED _____SEPARATED ____WIDOWED

HOW LONG _____ SPOUSE'S NAME: _____

NUMBER OF CHILDREN: _____

DO YOU PROVIDE FINANCIAL SUPPORT FOR YOUR CHILDREN? _____

AMOUNT? _____ FREQUENCY? _____

NAME OF CHILD:	LIVE WITH YOU?	GENDER	DATE OF BIRTH
_____	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 ____SNORT ____DRINK ____PILLS ____SHOOT _____ 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 ____SNORT ____DRINK ____PILLS ____SHOOT _____ 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 ____SNORT ____DRINK ____PILLS ____SHOOT _____ OTHER _____

   HOW OFTEN DID YOU USE IT? _____

   WHAT AMOUNT DID YOU USUALLY USE? _____

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

MEDICAL/PSYCHIATRIC HISTORY IF KNOWN

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

Dates of admission	Name of Hospital	City	State	Reason for Admission

CURRENT MEDICAL DIAGNOSIS: _____

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 MENTAL HEALTH OR PAIN MEDICATION(S)? _____

MEDICATION: _____ PRESCRIBING DOCTOR: _____

MEDICATION: _____ PRESCRIBING DOCTOR: _____

MEDICATION: _____ PRESCRIBING DOCTOR: _____

MEDICATION: _____ PRESCRIBING DOCTOR: _____

REFERENCE (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: (_____) _____-_____

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

_____ _____

Applicant Signature ***Date***

I understand participation in this program is based upon meeting criteria, providing and completing necessary paperwork, completion of mental health evaluation to determine whether you suffer from a condition that is or reasonably could be related to your military service and that your condition caused or contributed to the criminal offense that you have been charged with notification of approval as determined by the Veterans Court Team. I understand the intake interview and submission to program does not mean I am accepted and as such, I am required to follow all current bonds, pretrial, or court ordered conditions

I understand my military service and discharge type will be verified by the Department of Veterans Affairs.

_____ _____

Applicant Signature ***Date***

DALLAS COUNTY VETERAN TREATMENT COURT PROGRAM PARTICIPANT VOLUNTARY WAIVER OF CONFIDENTIALITY AND CONSENT FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

(Disclosure with client's consent as per Title 42, Chapter 1, Part 2 Federal Register)

I, _____, voluntarily waive my rights of confidentiality and authorize all Dallas County Community Supervision and Corrections Department personnel and VETERANS COURT staff to request and receive information or records from any person including myself, or any agency having information or records concerning my medical, psychological, or psychiatric history and any information or records pertaining to diagnosis, condition or treatment of a medical, psychological or psychiatric nature including acquired immune deficiency syndrome (AIDS), human immunodeficiency virus (HIV), or any AIDS related complex as necessary in order to facilitate my voluntary involvement in the Dallas County VETERANS TREATMENT COURT PROGRAM.

The VETERANS TREATMENT COURT PROGRAM Staff includes the Presiding Judge, the Criminal District Attorney or his designated Assistant Criminal District Attorney, the Chief Public Defender or her designated Deputy Public Defender, designated Officers of the Community Supervision Department including supervisors and health care professionals, and employees of the United States Department of Veterans Affairs (VA) and of the Veterans Benefits Administration (VBA).

I further waive my rights of confidentiality and authorize any agency, doctor, hospital or treatment facility to disclose any and all information or records requested by any Dallas County Community Supervision and Corrections Department personnel or VETERANS TREATMENT COURT PROGRAM staff as deemed necessary by the VETERANS TREATMENT COURT PROGRAM staff to facilitate treatment and care or to monitor my participation in VETERANS TREATMENT COURT PROGRAM.

I further waive my rights of confidentiality and authorize Dallas County Community Supervision and Corrections Department personnel or VETERANS TREATMENT COURT PROGRAM staff to disclose any and all acquired information or records to the following:

1. The Judge having authority over my case and the personnel of the Court.
2. Other Dallas County Community Supervision and Corrections Department involved in the supervision and maintenance of my supervision file.
3. Personnel of any department to which my case my may be transferred for supervision.
4. Personnel of any residential treatment facility in which I may be placed, including the Dallas Community Judicial Treatment Center.
5. Personnel of any institution/facility to which I may be committed.
6. Personnel of any treatment/diagnostic program to which I may be assigned.
7. Personnel form the District Attorney's Office.
8. My Attorney of record.
9. Texas Department of Criminal Justice, Community Justice Administrative Division.
10. The United States Department of Veterans Affairs.

This waiver is limited to communication made to and among the persons or agencies referenced above and I do not waive my rights of confidentiality in regards to any other individual or agency not so included. I understand the purpose of this waiver is to facilitate the supervision of my case and I may revoke this waiver at any time. If not earlier revoked by me, this waiver expires thirty (30) days after my graduation form Veterans Treatment Court Program (resulting in the dismissal of criminal charges

before the Veterans Treatment Court Program or immediately upon my voluntary or involuntary termination from Veterans Treatment Court Program prior to successful completion.

I understand that my records are protected by the Code of Federal Regulations, Part 2 of Title 42 governing confidentiality of alcohol and drug abuse client records and that recipient of this information may disclose it within the agreement of this signed agreement.

I understand one purpose of, and need for, this disclosure is to inform the court and all other named parties of my eligibility and/or acceptability for substance abuse treatment services and my treatment attendance, prognosis, compliance and progress in accordance with the VETERANS TREATMENT COURT PROGRAM monitoring criteria. This information may be released through verbal, written or electronic communication.

I understand that this consent will remain in effect and cannot be revoked by me until there has been a formal and effective termination of my involvement with VETERANS TREATMENT COURT PROGRAM for the above referenced case(s), such as the discontinuation of all supervision and/or, where relevant, dismissal off the charges and/or, where relevant, the assignment of this case to a division other than the VETERANS TREATMENT COURT PROGRAM.

I understand that any disclosure made is bound by Part 2 of Title 42 of the Code of Federal Regulations, which governs the confidentiality of substance abuse patient records and that recipients of the information may re-disclose it only in connection with their official duties.

I have read or have had read to me the terms and conditions of this agreement and fully understand same. I do hereby, freely, knowingly, and intelligently agree to those terms and conditions.

_____ _____

Veteran (Print Name) Date

_____

Veteran (Signature)

_____ _____

Name of Attorney for Veteran (Print Name) Texas Bar Number

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

PRIVACY ACT AND PAPER WORK REDUCTION ACT INFORMATION: 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 Act. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless is 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 the instructions, gather the necessary facts and fill out this form. 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. VA 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", 08VA05 "Employee Medical File System Records (Title 38)-VA" and in accordance with the Notice of Privacy Practices. VA may also use this information to identify veterans and person 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):

VA North Texas Health Care System, 4500 S. Lancaster, Dallas, TX 75216 and any other VHA hospital system where the Veteran has or will receive services.

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

Dallas Co. VTC, 133 N. Riverfront Blvd., Dallas, TX 75207. 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. _____ Initial Here

PURPOSE(S) OR NEED: Information is to be used by the organization or individual for

☒ Treatment ☐ Benefits ☒ Legal ☐ Employment ☐ Other – Please specify._____

_____

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

- ☐ Health Summary (prior 2 years)
- ☐ Inpatient Discharge Summary (dates): _____
- ☒ Progress Notes:
  - ☒ Specific clinics (name & date range): All mental health, medical, & substance abuse notes.
  - ☐ Specific providers (name & date range): _____
  - ☐ Date range: _____
- ☐ Operative/Clinical Procedures (name &date): _____
- ☒ Lab results:
  - ☒ Specific tests (name & date): All drug utox screens past and future deemed relevant by the court.
  - ☐ Date range: _____
- ☐ Radiology Reports (name & date): _____
- ☒ List of Active Medications
- ☐ Flu Vaccination (dose, lot number, date & location)
- ☒ Other (describe below): Appointment information, problem list, & all relevant medical information needed for court supervision.

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

SENSITIVE DIAGNOSES: REVIEW AND, IF APPROPRIATE, COMPLETE WHEN RELEASE IS FOR ANY PURPOSE OTHER THAN TREATMENT.

I request and authorize the Department of Veterans Affairs to release the information pertaining to the condition(s) below for the non-treatment purpose(s) listed in this authorization:

☐ Drug Abuse ☐ Alcoholism or Alcohol Abuse ☐ Sickle Cell Anemia
☐ Human Immunodeficiency Virus (HIV)

I understand that information on these sensitive diagnoses may be released for treatment purposes without me checking the above boxes, and will be released even if the boxes are unchecked unless I indicate by checking the box below that I do not want this information released for this specific disclosure.

☐ **I do not want sensitive diagnoses released for treatment purposes under this specific authorization. I realize this does not impact other future requests unrelated to this authorization.**

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion, or because a condition of VA employment mandates the signing of this authorization. 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 information disclosed per this authorization may no longer be protected by Federal confidentiality laws or regulations and may be subject to re-disclosure by the recipient.

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

☐ After one-time disclosure, if all needs are satisfied
☐ 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 verification from court that VA recs are no longer required; 3. Upon court completion.

•PATIENT SIGNATURE	DATE (mm/dd/yyyy)
LEGAL REPRESENTATIVE SIGNATURE (if applicable)	**DATE (mm/dd/yyyy)**

PRINT NAME OF LEGAL REPRESENTATIVE	RELATIONSHIP TO PATIENT

FOR VA USE ONLY

Type and Extent of Material Released: VJO will provide summary of progress via written, verbal, telephonic, fax, and/or secured email that is required by the court for monitoring of Veteran treatment progress and compliance. Data will be inclusive of all relevant medical record information, but not to be limited to: diagnoses (medical, mental health, & substance abuse), relevant labs, progress in treatment programming, developmental, social, financial, & military data relevant to court/legal circumstances. Medical record information is subject to review in open court.

Date Released:	Released by:

Department of Veterans Affairs	REQUEST FOR AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

PRIVACY ACT AND PAPER WORK REDUCTION ACT INFORMATION: 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 Act. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless is 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 the instructions, gather the necessary facts and fill out this form. 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. VA 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", 08VA05 "Employee Medical File System Records (Title 38)-VA" and in accordance with the Notice of Privacy Practices. VA may also use this information to identify veterans and person 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):
VA North Texas 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
Hollie Fikes, MS, LPC/Dallas Co. Veterans Treatment Court, Crowley Courts Bldg., Community Supervision Dept., 9th fl., ATRS Dept., 133 N. Riverfront Blvd., Dallas, TX 75207; fax: 214-653-2874.

PURPOSE(S) OR NEED: Information is to be used by the organization or individual for

☐ Treatment ☐ Benefits ☒ Legal ☐ Employment ☒ Other – Please specify. Continuity of care; current treatment status/adherence; records can be faxed/mailed.

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

☒ Health Summary (prior 2 years)
☐ Inpatient Discharge Summary (dates): _____
☒ Progress Notes:
  ☒ 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): _____
☒ Lab results:
  ☒ Specific tests (name & date): Medication and drug/alcohol urinalysis.
  ☒ Date range: Prior 1 year
☐ Radiology Reports (name & date): _____
☒ List of Active Medications
☐ Flu Vaccination (dose, lot number, date & location)
☒ Other (describe below): Appointment information, C&P exams, problem list, medications, and discharge summaries.

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

SENSITIVE DIAGNOSES: REVIEW AND, IF APPROPRIATE, COMPLETE WHEN RELEASE IS FOR ANY PURPOSE OTHER THAN TREATMENT.

I request and authorize the Department of Veterans Affairs to release the information pertaining to the condition(s) below for the non-treatment purpose(s) listed in this authorization:

☐ Drug Abuse ☐ Alcoholism or Alcohol Abuse ☐ Sickle Cell Anemia

☐ Human Immunodeficiency Virus (HIV)

I understand that information on these sensitive diagnoses may be released for treatment purposes without me checking the above boxes, and will be released even if the boxes are unchecked unless I indicate by checking the box below that I do not want this information released for this specific disclosure.

☐ **I do not want sensitive diagnoses released for treatment purposes under this specific authorization. I realize this does not impact other future requests unrelated to this authorization.**

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion, or because a condition of VA employment mandates the signing of this authorization. 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 information disclosed per this authorization may no longer be protected by Federal confidentiality laws or regulations and may be subject to re-disclosure by the recipient.

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

☐ After one-time disclosure, if all needs are satisfied

☐ 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 verification from court that VA records are no longer required; 3. Upon court completion.

PATIENT SIGNATURE	DATE (mm/dd/yyyy)
LEGAL REPRESENTATIVE SIGNATURE (if applicable)	**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:

To be completed by applicant

1. Please explain in your own words how you believe your experiences during your military service contributed to the behavior resulting in this arrest.

Please write on the back if you need additional space

2. The Dallas County Veterans Treatment Court is a treatment court designed to address mental health conditions (psychiatric, substance, cognitive impairments) arising from experiences during military service. Please explain how your military service has resulted in a mental health condition (psychiatric, substance, cognitive impairments) which may be addressed through a treatment court program.

Please write on the back if you need additional space

3. Why do you want to be in the Dallas County Veterans Treatment Court program and what do you hope to achieve through participation?

NOTICE TO ATTORNEYS

CASES NEVER ELIGIBLE FOR VTC: SEX CASES, MAN/DEL CASES, CASES INVOLVING DEATH OF A VICTIM.

PLEASE ADVISE YOUR CLIENT OF THE FOLLOWING BEFORE APPLYING TO VETERANS TREATMENT COURT:

1.) You are not eligible for VTC if you have ever participated in a VTC in another county, and had your case dismissed or expunged as a result. You must sign an affidavit (located in application packet) swearing that you have not done such in order to be considered for participation in Dallas County VTC.

2.) Veterans Treatment Court has a statutory minimum duration of 6 months, but a participant could be in the program for as long as the legally allowable term of probation associated with his or her charge. The duration of the program within the abovementioned timeframe is determined by each participant's treatment plan and individual progress. If you do not have a mental health or substance abuse problem that requires treatment you are not eligible.

3.) This is a TREATMENT COURT. You must have a mental health and/or substance abuse problem in need of treatment in order to be eligible.

4.) Treatment may be recommended on an inpatient and/or outpatient basis.

5.) If you won't agree to participate in recommended treatment you are not eligible.

6.) All participants are subject to the requirement of a SCRAM, Soberlink, Interlock, drug patch or other similar monitoring device if deemed necessary by the VTC team.

7.) You will be required to come to court 1x/week, report to your supervision officer 1x/week, treatment classes/groups as recommended, and are subject to being required to appear on a random basis for UAs.

Please sign below acknowledging your understanding of the above terms and conditions as they relate to application and participation in Veterans Treatment Court before proceeding with the application.

_____ _____

Attorney for Applicant Veterans Treatment Court Applicant

See Art. 55.01(a)(2)(A)(ii)(a-3)

Art. 55.01. RIGHT TO EXPUNCTION. **(a) A person who has been placed under a custodial or noncustodial arrest for commission of either a felony or misdemeanor is entitled to have all records and files relating to the arrest expunged if:**

(1) the person is tried for the offense for which the person was arrested and is:

(A) acquitted by the trial court, except as provided by Subsection (c); or

(B) convicted and subsequently:

(i) pardoned for a reason other than that described by Subparagraph (ii); or

(ii) pardoned or otherwise granted relief on the basis of actual innocence with respect to that offense, if the applicable pardon or court order clearly indicates on its face that the pardon or order was granted or rendered on the basis of the person's actual innocence; or

(2) the person has been released and the charge, if any, has not resulted in a final conviction and is no longer pending and there was no court-ordered community supervision under Chapter 42A for the offense, unless the offense is a Class C misdemeanor, provided that:

(A) regardless of whether any statute of limitations exists for the offense and whether any limitations period for the offense has expired, an indictment or information charging the person with the commission of a misdemeanor offense based on the person's arrest or charging the person with the commission of any felony offense arising out of the same transaction for which the person was arrested:

(i) has not been presented against the person at any time following the arrest, and:

(a) at least 180 days have elapsed from the date of arrest if the arrest for which the expunction was sought was for an offense punishable as a Class C

misdemeanor and if there was no felony charge arising out of the same transaction for which the person was arrested;

(b) at least one year has elapsed from the date of arrest if the arrest for which the expunction was sought was for an offense punishable as a Class B or A misdemeanor and if there was no felony charge arising out of the same transaction for which the person was arrested;

(c) at least three years have elapsed from the date of arrest if the arrest for which the expunction was sought was for an offense punishable as a felony or if there was a felony charge arising out of the same transaction for which the person was arrested; or

(d) the attorney representing the state certifies that the applicable arrest records and files are not needed for use in any criminal investigation or prosecution, including an investigation or prosecution of another person; or

(ii) if presented at any time following the arrest, was dismissed or quashed, and the court finds that the indictment or information was dismissed or quashed because:

(a) the person completed a veterans treatment court program created under Chapter 124, Government Code, or former law, subject to Subsection (a-3);

(b) the person completed a pretrial intervention program authorized under Section 76.011, Government Code, other than a veterans treatment court program created under Chapter 124, Government Code, or former law;

(c) the presentment had been made because of mistake, false information, or other similar reason indicating absence of probable cause at the time of the dismissal to believe the person committed the offense; or

(d) the indictment or information was void; or

(B) prosecution of the person for the offense for which the person was arrested is no longer possible because the limitations period has expired.

(a-1) Notwithstanding any other provision of this article, a person may not expunge records and files relating to an arrest that occurs pursuant to a warrant issued under Article 42A.751(b).

(a-2) Notwithstanding any other provision of this article, a person who intentionally or knowingly absconds from the jurisdiction after being released under Chapter 17 following an arrest is not eligible under Subsection (a)(2)(A)(i)(a), (b), or (c) or Subsection (a)(2)(B) for an expunction of the records and files relating to that arrest.

(a-3) A person is eligible under Subsection (a)(2)(A)(ii)(a) for an expunction of arrest records and files only if:

(1) the person has not previously received an expunction of arrest records and files under that sub-subparagraph; and

(2) the person submits to the court an affidavit attesting to that fact.

DALLAS COUNTY VETERANS TREAMTENT COURT
CODE COMPLIANCE AFFIDAVIT

THE STATE OF TEXAS

BEFORE ME, _____

COUNTY OF DALLAS

A Notary Public in and for said County, State of Texas, on this day personally appeared, _____, who, after being by me duly sworn, on oath deposes and says that I am competent and qualified to make this affidavit and I have personal knowledge of the fact stated herein and they are true and correct:

I.

I further declare that:

In compliance with Texas Code of Criminal Procedure Art. 55.01(a)(2)(A)(ii)(a-3) I am applying to Dallas County Veterans Court in good faith, swearing, through this affidavit, that I have never before received an expunction as a result of completion of any veterans treatment court.

I HAVE PERSONAL KNOWLEDGE OF THE ABOVE AND I SWEAR THAT THE ABOVE STATEMENTS ARE TRUE AND CORRECT.

_____
AFFIANT

SUBSCRIBED AND SWORN TO BEFORE ME THIS _____DAY OF _____, 20____.

_____
NOTARY PUBLIC
Dallas County, Texas

Commission expires _____day of _____, _____.