

THE COURT SUPERVISED
TREATMENT COURT PROGRAM OF SWEETWATER COUNTY
REQUEST FOR ADMISSION AND
INFORMATIONAL INTAKE FORM

Please fill out INTAKE completely:

Today's Date: _____

NAME: _____

DOB: _____ SS#: _____

WHERE BORN: _____ Are you a U.S. citizen. YES /
NO

ADDRESS (where you will be living): _____

TELEPHONE NUMBERS: (All numbers where you can be reached) _____

How long have you lived in this area? _____ Do you plan to stay in this area? _____
What are your connections to Sweetwater County? _____

How many times have you moved in the last year? _____

CURRENT OFFENSE: _____

DATE OF CURRENT OFFENSE: _____

PLEA: _____

JUDGE: _____

COUNTY ATTORNEY: _____

DEFENSE ATTORNEY: _____

IMPORTANT: List any charges in any other court or jurisdiction that is not resolved or completed.

IDENTIFIERS:

EYES: _____ HAIR: _____ HEIGHT/WEIGHT: _____

RACE: _____

SCARS/MARKS/PIERCINGS: Be Specific _____

EDUCATION:

Highest Grade Level Completed: _____ Name of School: _____
Did you receive a Diploma? _____ GED? _____ What Year? _____
If you quit school, when did you quit and why? _____

EMPLOYMENT (Please go back 10 years or since 18 years of age.):

Are you currently employed: _____ How many months have you worked in the past year? _____
Present Employer: _____ What do you make per hour? _____
How many hours per week? _____ Date started: _____ Position: _____

Previous Employer:

Dates employed: _____
Position: _____
Why Left: _____

Previous Employer:

Dates employed: _____
Position: _____
Why Left: _____

If you need more room for listing employment please use the back of this application.

SPOUSE/SIGNIFICANT OTHER:

His/Her Name _____ Address: _____
Telephone number: _____ Birthdate: _____
Occupation: _____ Highest level of school: _____
If married, how long _____ If living together, how long _____
If divorced or separated, how long? _____ How old were you when you married? _____
Do they consume alcohol or use illicit drugs? _____
What, frequency, amounts: _____
Have they ever received addiction treatment? _____ Where/When _____
Have they ever been abusive to you/others? _____
Have they ever been incarcerated for 30 days or more? _____
For what? _____

HOW MANY CHILDREN DO YOU HAVE:

Name: _____ Date of Birth: _____ Address: _____
Name: _____ Date of Birth: _____ Address: _____
Name: _____ Date of Birth: _____ Address: _____
Name: _____ Date of Birth: _____ Address: _____
Who has custody of the above listed children? _____
How many children live with you. _____
Which ones: _____

PRIOR MARRIAGES OR RELATIONSHIPS:

How many prior marriages and significant relationships: _____
To Whom: _____ Dates _____
To Whom: _____ Date of Married/Divorce _____
Reason For Divorce: _____
Do you pay child support: _____ How much: _____

Are you current in paying child support? _____ If you are in arrears, how much? _____
Do you receive child support: _____ How much: _____

DO YOU LIVE WITH SOMEONE OTHER THAN A SPOUSE OR SIGNITIFANT OTHER? (Parents, relative, roommate) Names: _____

Phone: _____

Ages: _____ Is that person or anyone in your household on probation? _____

If so, for what? _____

Does anyone in this household use alcohol or illicit drugs? **YES / NO**

How long have you lived with this person(s). _____

Where did you reside before that and how long: _____

Where did you reside before that and how long: _____

PARENTS:

Father: _____ Date of Birth _____ Address: _____

Mother: _____ Date of Birth _____ Address: _____

Step-Father: _____ Date of Birth _____ Address: _____

Step-Mother: _____ Date of Birth _____ Address: _____

Were you neglected or abused as a child? **YES / NO**

Was anyone else in your household abused when you were a child? **YES / NO**

SIBLINGS:

Name: _____ Date of Birth _____ Address: _____

Name: _____ Date of Birth _____ Address: _____

Name: _____ Date of Birth _____ Address: _____

Name: _____ Date of Birth _____ Address: _____

Do any of them have problems with Drugs or Alcohol? _____

Do any of them have legal problems? _____

TRANSPORTATION

It is a requirement of the Treatment Program that you have reliable transportation to and from treatment, to and from probation, to and from court, to and from self-help meetings.

Please indicate what your plans are for reliable transportation while in the Treatment Program. _____

Do you own a vehicle? _____ Do you have a valid driver's license? _____

License Number: _____ Do you have insurance on the vehicle? _____

Name of Insurance Company _____

Describe the vehicles you drive: (make, model, year, color, license plate number, if known)

Primary vehicle: _____

Secondary vehicle: _____

COMMUNICATION: In addition to reliable transportation, the Treatment Program will require you to

have a cell phone and possibly a land line telephone. You may also be placed on a monitor for the first part of Level I of Treatment Program. Probation and Parole, Case Manager, and Treatment must be able to locate you at any given time.

PRIOR CRIMINAL HISTORY:

At what age did you commit your first criminal act? _____ Age of first arrest? _____

Have you ever been charged with a violent crime? **YES / NO**

List prior offense history and the disposition (sentence you received) for each offense, and include your current offense. Also please list date, city and state of past offences.

Have you had any additional disciplinary actions while incarcerated? _____ If so, explain:

Write your version of what happened with respect to the crime with which you are presently charged:

How much jail time is likely for the crime you are being charged with. _____

Have you previously been on probation? _____ Has your probation ever been revoked? _____

Explain: _____

Have you ever been in a correctional facility before? **YES / NO** List when and where: _____

HEALTH:

Are you in good health? _____ When was your last Physical? _____ Illness in the last 30 days? **YES/NO**

Do you have vision problems? _____ Do you have dental problems? _____

List any current prescribed medications and for what they are prescribed: _____

List disabilities or chronic conditions: _____

Do you receive disability benefits _____ Do you have health insurance? _____ With whom? _____

MENTAL HEALTH:

In the **past year** have you experienced a significant period of time with the following? (not as a result of drug/alcohol use or during periods of withdrawal. **Circle all that apply.**

- Serious depression Serious anxiety Hallucinations
- Trouble controlling violent behavior Serious thoughts of suicide
- Trouble understanding or concentrating Attempted suicide

In the **past year**, have you been prescribed medication for a psychological or emotional problem? **YES / NO**

If so, what medication? _____

Have you **ever** been diagnosed with a mental health or personality disorder? **YES / NO**

If so, what? _____

Do you have trouble sleeping? **YES / NO** Do you have anxiety? **YES / NO**

SUBSTANCE ABUSE:

Prior to acceptance into the Treatment Program, you are required to obtain a substance abuse evaluation. More than likely you have already been required by the court in which you are charged to have this evaluation. If you are accepted into the Treatment Program, the Program will consider paying for your evaluation. Until then, it will be your responsibility to do so.

Do you smoke tobacco? **YES/NO** Do you chew tobacco? **YES/NO**

How old were you when you first tried alcohol or another drug? _____ What was it? _____

Have you ever had an alcohol/drug evaluation? **YES/NO** When and where was it? _____

Have you been diagnosed with chemical dependency? **YES/NO** What substance(s)? _____

Have you ever gone to counseling or treatment for addiction? **YES / NO**

Please list treatment episodes, where it was provided, if it was out-patient or residential, and if you successfully completed the program:

Circle the drugs which you have used more than 10 times: marijuana, cocaine, methamphetamine, mushrooms, ecstasy, crack, crank, prescription pills, other: _____.

What is/are your current drug(s) of choice? _____

Do you consume alcohol? **YES/NO** How often? _____

How much at one time? _____

Do you abuse prescription drugs? Do you have a prescription for this drug? _____

Drugs used in the past year	Age first used	How often	Last used
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever injected drugs? **YES / NO** If so, when, what and how often? _____

How much do you spend a month to support your addictions? _____

FINANCES

What is the source of the money on which you have recently been living? i.e. wages, child support, disability payments, pension, food stamps, subsidized housing, living with relatives, etc _____

Living Expenses:

Do you rent or own your home? _____ How much do you pay monthly for mortgage/rent? _____

How long have you lived at this address? _____

What is the total you pay for utilities? _____

Do you pay for child care and/or child support? YES/NO If yes, how much? _____

Do you have credit cards? Yes/No Approximately what is your credit card debt? _____

Do you have a car payment? Yes/No How much? _____ How much do you owe on the car? _____

Car insurance payment? _____ To whom? _____

Medical bills: _____ To whom? _____

School loans: _____

Bank loans: _____

Please list any other expenses and/or debts you have: _____

How much do you have to make a month to cover your living expenses? _____

What are your monetary obligations to the courts:

Fines and restitution: _____ What Court? _____

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Fines and restitution: _____ What Court? _____

Fines and restitution: _____ What Court? _____

What is your estimate of your total outstanding debt? _____

YOUR REASONS FOR PLACEMENT IN THE TREATMENT PROGRAM:

Do you believe that you need substance abuse treatment? YES / NO

Do you believe that substance abuse treatment would be effective for you? YES / NO

How did you first learn of the Treatment Program?

Tell us anything more you would like us to know and consider about you and your situation. Tell us your reasons for wanting in the Treatment Program. What do you think you would get out of the program?

Confidentiality:

I, understand that the Treatment Program of Sweetwater County files are confidential. That I must sign releases for all information regarding my participation in the Treatment Program. I understand that I may not discuss, relay, transcribe, and/ or confer any information I may learn about any Treatment Program of Sweetwater County participant with anyone other than The Treatment Program of Sweetwater County team members. I understand that by attending the Treatment Program of Sweetwater County hearings I may not discuss to any person outside of the Treatment Program of Sweetwater County program any information identifying any participant in the Treatment Program of Sweetwater County program.

I understand that any violation of the confidentiality of drug and/or alcohol treatment records disclosure requirements is a federal crime.

I would like to apply for the Treatment Program. If I am accepted, I understand that:

- I must live in an approved drug/alcohol/weapon free environment during my time in the Treatment Court Program.
- I must have a working, charged cell phone with adequate minutes with me at all times.
- I will be subject to an enhanced supervision with restrictions that could include, but are not limited to,
 - residential confinement,
 - curfews,
 - immediate sanction(s), such as
 - electronic monitoring and/or
 - county jail time, and
 - increased contact with probation agent(s), law enforcement officers, attorneys, the courts, and treatment providers.
- Any contact with others must be approved by my probation agent prior to contact. No social media will be approved.
- I will be required to attend treatment, probation and parole visits, court hearings, and self-help meetings.

- I will be on a strict schedule and cannot deviate from that schedule unless I have permission from my probation agent.
- I will have limited time in the community but this will increase as I work through and complete the phases.
- I will be charged and must pay \$15 per week while in the Program.
- I will be required to be a productive citizen through work, education, and/or community service.

Signature of Applicant

Date

Witness

FOR OFFICIAL USE ONLY

County Attorneys:

Cr. History: Disqualifications:

Treatment: ASAM Level: _____

Legal Disposition: _____

Official Use Only:

Accepted/denied as Treatment Program candidate; YES _____ NO _____

Date of acceptance: _____

Reason for Denial _____

Notes:

**AUTHORIZATION FOR THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION
- Psychotherapy Notes AND Substance Abuse Records -**

This authorization fully complies with the standards set forth by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I _____, authorize the following individuals, entities or agents to make the authorized use and/or disclosure of my protected health information (PHI):

I authorize the aforementioned individuals, entities, or agents to release and/or disclose the following information:

_____ Initial here if requesting a copy of the substance abuse and clinical evaluation completed at

_____ Initial here if requesting all Psychotherapy notes or substance abuse records. Psychotherapy Notes are notes that a mental health professional makes, in any medium, that document or analyze the contents of conversations during private, group, joint or family counseling sessions and that are separated from the rest of the individual's medical record. Includes medication, prescription, monitoring; counseling session start and stop times; treatment modalities and frequencies; clinical test results; diagnosis, functional status, treatment plan, symptoms, prognosis, or progress summary.

I authorize the Treatment Court Program of Sweetwater County to receive my protected health information, for purposes of obtaining information which may be required regarding my participation with the Treatment Program.

I authorize all clinicians, case managers, physicians, dentists, medical practitioners, nurses, pharmacists, hospitals, medical examiners, affiliated with the above-listed entity to be interviewed by the Treatment Program of Sweetwater County, and/or their agent.

I understand that this consent is subject to revocation at any time except to the extent that the program which is to make the disclosure has already taken action in reliance on it. If not previously revoked, this Authorization shall remain in full force and effect for a period of two (2) years from the date set forth below, the duration of term as participant in the Treatment Court Program of Sweetwater County, or termination from the Treatment Program, whichever comes first.

A photostatic copy of this Confidential Release of Records may be accepted in lieu of the original and shall be as fully binding as though it were the original executed by me.

Dated this _____ day of _____, 2017/2018.

Dob: _____ **SSN#** _____

STATE OF WYOMING)
): ss.
COUNTY OF SWEETWATER)

Acknowledged before me by _____, this _____ day of _____, 2017/2018.

WITNESS my hand and official seal.
(SEAL)

Notary Public

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.

**AUTHORIZATION FOR THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION
- Psychotherapy Notes or Substance Abuse Records -**

This authorization fully complies with the standards set forth by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I, _____, authorize the following individual, entity or agent to make the authorized use and/or disclosure of my protected health information (PHI):

SWEETWATER COUNTY DETENTION CENTER AND SWEETWATER COUNTY SHERIFF'S OFFICE

I authorize the aforementioned individual, entity, or agent to release and/or disclose the following information:

_____ Initial here if requesting all Psychotherapy notes and/or substance abuse records. Psychotherapy Notes are notes that a mental health professional makes, in any medium, that document or analyze the contents of conversations during private, group, joint or family counseling sessions and that are separated from the rest of the individual's medical record. Includes medication, prescription, monitoring; counseling session start and stop times; treatment modalities and frequencies; clinical test results; diagnosis, functional status, treatment plan, symptoms, prognosis, or progress summary.

I authorize the Treatment Program of Sweetwater County to receive my protected health information, or any other information from the Detention Center for purposes of obtaining information which may be required regarding my participation with The Treatment Program.

I authorize the Treatment Court Program of Sweetwater County to receive my protected health information, for purposes of obtaining information which may be required regarding my participation with the Treatment Program.

I authorize all clinicians, case managers, physicians, dentists, medical practitioners, nurses, pharmacists, hospitals, medical examiners, affiliated with the above-listed entity to be interviewed by the Treatment Program of Sweetwater County, and/or their agent.

I understand that this consent is subject to revocation at any time except to the extent that the program which is to make the disclosure has already taken action in reliance on it. If not previously revoked, this Authorization shall remain in full force and effect for a period of two (2) years from the date set forth below, the duration of term as participant in the Treatment Court Program of Sweetwater County, or termination from the Treatment Program, whichever comes first.

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Dated this _____ day of _____, 2017/2018.

Dob: _____ **SSN#** _____

STATE OF WYOMING)
 : ss.
COUNTY OF SWEETWATER)

Acknowledged before me by _____, this _____ day of _____, 2017/2018

WITNESS my hand and official seal.
(SEAL)

Notary Public

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.

AUTHORIZATION FOR THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

- Psychotherapy Notes AND Substance Abuse Records -

This authorization fully complies with the standards set forth by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I, _____, authorize the following individuals, entities or agents to make the authorized use and/or disclosure of my protected health information (PHI):

DEPARTMENT OF FAMILY SERVICES

I authorize the aforementioned individuals, entities, or agents to release and/or disclose the following information:

_____ Initial here if requesting all Psychotherapy notes or substance abuse records. Psychotherapy Notes are notes that a mental health professional makes, in any medium, that document or analyze the contents of conversations during private, group, joint or family counseling sessions and that are separated from the rest of the individual's medical record; includes medication, prescription, monitoring, drug testing; counseling sessions start and stop times; treatment modalities and frequencies; clinical test results; diagnosis, functional status, treatment plan, symptoms, prognosis, or progress summary, personal and family information.

_____ Initial here if requesting all applications for Medicare, Medicaid and other benefits provided through DFS.

_____ Initial here if requesting all communication regard minor children with regards to visitations, children's physical and mental conditions, or any other necessary information regarding the minor children and his/her connection with them and with visitation of the children.

I authorize the Treatment Court of Sweetwater County to receive my protected health information, for purposes of obtaining information which may be required regarding my participation with Treatment Court.

I authorize all clinicians, physicians, dentists, medical practitioners, nurses, pharmacists, hospitals, medical examiners, affiliated with the above-listed entity to be interviewed by Treatment Court of Sweetwater County, and/or their agent regarding my child/children, or myself.

I understand that if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.

I understand that this consent is subject to revocation at any time except to the extent that the program which is to make the disclosure has already taken action in reliance on it. If not previously revoked, this Authorization shall remain in full force and effect for a period of two (2) years from the date set forth below, the duration of term as participant in the Treatment Court Program of Sweetwater County, or termination from the Treatment Program, whichever comes first.

A photo static copy of this Confidential Release of Records may be accepted in lieu of the original and shall be as fully binding as though it were the original executed by me.

DATED this ___ day _____, 2017/2018.

Dob: _____ SSN# _____

STATE OF WYOMING)
COUNTY OF SWEETWATER) : ss.

Acknowledged before me by _____, this _____ day of _____, 2017/2018.

WITNESS my hand and official seal.

(SEAL)

Notary Public

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TARGET POPULATION

4. TARGET POPULATION:

- ❖ History of Substance-Abuse and Addiction Offenders identified by WS 7-13-1601 et seq.
- ❖ Defendants with felony property crimes related to drug and /or alcohol use
- ❖ Felony Probation Revocation where primary reason is the Defendant's use of drugs and/or alcohol
- ❖ Offenders charged with Child Endangerment due to substance abuse
- ❖ Offenders with recommendation for substance abuse treatment (ASAM level II.1 or higher)
- ❖ Persons at least 18 years of age or legally emancipated

5. APPLICANTS MUST MEET THE FOLLOWING ELIGIBILITY REQUIREMENTS:

- ❖ Offender must be charged and residing in Sweetwater County, Wyoming
- ❖ Residents of Sweetwater County, who have offended in another Wyoming County, wherein it can be reasonably worked out for his/her entry into our program and they meet the other qualifying factors
- ❖ Treatment is to be done in Wyoming
- ❖ Voluntarily agree to participate in treatment court
- ❖ Offender must possess or acquire a cell phone
- ❖ Offender must have or arrange reliable transportation

6. APPLICANTS MAY BE DISQUALIFIED FOR THE FOLLOWING:

- ❖ Unresolved charges in other jurisdiction
- ❖ A history of violence and/or antisocial behavior unassociated with substance abuse
- ❖ Acute unmanageable mental health and psychiatric issues which are the primary presenting problems
- ❖ A history of predatory sexual offences either convicted or un-convicted.

Factors not considered: race, gender, religious affiliations, creed, color, sexual orientation, national origin.

Each applicant is considered on a case by case basis and the Treatment Court Program Team must determine if the applicant is appropriate for inclusion into the program at the time of application.