

Ross County Drug Court Program
Application Form

Applicant Information:

Full Name: _____ Date: _____

Case Number, Offense, and Degree of Felony and/or Misdemeanor: _____

SSN: _____ DOB: _____

Address: _____

Telephone Numbers: _____ (h) _____ (c) _____ (w)

Valid Driver's License: Yes No If no, state reason: _____

Emergency Contact: _____ Relationship: _____

Address: _____ Telephone: _____

Employer Name: _____ Employer Phone: _____

Full Time: Yes No Work Schedule: _____

Hourly Wage: \$ _____ Hire Date: _____

- Current Status: Motion for Intervention in Lieu of Conviction
 Pending Change of Plea and/or Sentencing
 Community Control Violation/Revocation
 Motion for Judicial Release

Next Court Hearing Date/Time: _____

Defense Attorney/Office Phone #: _____

Who lives with you or stays in the home on any kind of regular basis (check all that apply and provide names):

- Spouse _____
 Significant Other _____
 Children _____
 Parents _____
 Sister(s)/Brother(s) _____
 Grandparents _____
 Aunt(s)/Uncle(s) _____
 Cousin(s) _____
 Grandchildren _____
 Niece/Nephew _____
 Others _____

Does anyone in your household drink and/or use drugs? Yes No

Are you willing to/able to relocate, if necessary, to a safer environment? Yes No

If no, state reason _____

Do you have any alcohol/drug-free peers? Yes No

Do you have a problem with alcohol and/or drug use: Yes No

Are you willing to be in a treatment program for 12 to 18 months: Yes No

Do you have your own transportation? Yes No

If no, do you have another source of reliable transportation? Yes No

How will you get to Drug Court and treatment sessions? _____

Are you able to attend Drug Court Review Hearings at 1:00 p.m. on Mondays? Yes No

Have you ever served in the military? Yes No

Have you ever been affiliated with a gang or involved in gang-related activity, including while serving a prison term? Yes No

Mental Health:

Have you ever been diagnosed with a mental illness? Yes No

If yes, when, by whom, and what was the diagnosis? _____

Has anyone in your family been diagnosed with a mental illness? Yes No

If yes, who, and what was the diagnosis? _____

Are you on any psychotropic medications (antidepressants, mood stabilizers)? Yes No

If yes, name of drug and dosage: _____

Have you ever been physically or sexually abused: Yes No If yes, by whom, and when: _____

Are you suicidal or experiencing suicidal ideations? Yes No

Have you ever attempted suicide? Yes No If so, please list where and when you received any medical and/or psychiatric hospitalization or other treatment, if applicable. _____

Are you homicidal or experiencing homicidal ideations? Yes No

How do you deal with anger? _____

How do you deal with disagreements? _____

Substance Use/Abuse/Dependency/Addiction History:

Current Age: _____	Method of Use: Oral, nasal, smoke, IV	First time you used (Age and amount):	Last time you used (Date and amount):	Amount Typically Used: Be specific!	How often do you use? (daily, weekly, weekends, socially, never sober etc.)
Alcohol					
Cannabis					
Amphetamine (Ritalin, Adderall, Vyvanse)					
Methamphetamine					
Cocaine					
Crack					
Hallucinogens (LSD, PCP, Shrooms, Acid)					
MDMA/Ecstasy/ Molly/Bath Salts					
Inhalants					
Heroin					
Opiates/Pain Pills (Methadone, Suboxone, Vicodin, Percocet, Dilaudid, Morphine)					
Sedative/ Tranquilizers (Xanax, Klodopin, Valium, Ativan)					

List substances in order by **drug of choice**:

#1 _____ #2 _____

#3 _____ #4 _____

Have you ever experienced blackouts? Yes No

If yes, when and from which substance: _____

Have you ever experienced withdrawal symptoms? Yes No

If yes, when and from which substance: _____

Have you ever overdosed? Yes No

If yes, when and from which substance: _____

Have you had legal problems due to alcohol/drugs? Yes No

If yes, when and for what charges: _____

Have you tried to quit using alcohol and drugs, but found it difficult? Yes No

Does your personality change when using alcohol or drugs? Yes No

If so, in what manner? _____

What problems have you experienced as a direct result of your substance use: _____

Please indicate if you previously participated in any substance abuse treatment programs, and if so, list the program and dates of participation.

Have you previously been court-ordered to attend substance abuse treatment or counseling, but failed to do so? Yes No

Physical Health:

Do you have any current health problems? Yes No

If yes, please list: _____

Are you taking any medications (other than mental health meds)? Yes No

If yes, name of drug and dosage: _____

Do you have any disabilities? Yes No

If yes, please list: _____

Would your disability interfere with your ability to attend treatment? Yes No

If yes, in what way? _____

Do you have insurance? Yes No Medicare? Yes No Medicaid? Yes No

Insurance Provider: _____

Financial:

Are you employed? Yes No

Attending school? Yes No

If yes, please list the name, address, and phone number of your employer or school: _____

Full-time Part-time Position: _____ Rate of Pay: _____

Highest level of education: _____

If you and/or your household are receiving any of the benefits listed below, please check all that apply, and list the monthly amount received:

Disability:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Amount: \$ _____
Food Stamps:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Amount: \$ _____
ADC:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Amount: \$ _____
Unemployment:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Amount: \$ _____

What goals do you want to achieve in life? _____

Please provide any other information you believe is important to your current situation: _____

Defendant's signature: _____

Date: _____