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 (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 1:30 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

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Substance Use/Abuse/Dependency/Addiction History:

Substance	Age first used	Age/date of last use	Frequency (Times/month)	Daily use history (Yes/No)	Quantity	Method of use
Alcohol						
Marijuana						
Cocaine						
Heroin						
Suboxone						
Methadone						
Methamphetamine						
Ecstasy/MDMA						
Inhalants						
Hallucinogens (LSD, PCP, acid, psilocybin, peyote, etc.)						
Prescription medication (Vicodin, OxyContin, Ultram, Xanax, Adderall, Ritalin, Valium, etc.)						
Over-the-counter medication (DXM/Robitussin, codeine cough syrup, diet pills, etc.)						

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 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

_____

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? _____

_____

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:	☐ Yes ☐ No	Amount: $_____
Food Stamps:	☐ Yes ☐ No	Amount: $_____
ADC:	☐ Yes ☐ No	Amount: $_____
Unemployment:	☐ Yes ☐ 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: _____