Guadalupe County Veterans Treatment Court Application

The Guadalupe County Veterans Treatment Court ("VTC") Participant Handbook has been read and you understand the program and what's expected of you during the course of the program?

Yes / No; if no, please read the handbook before you proceed.
(circle one)

This is a treatment court, and it takes a minimum of 14 months to complete the program; which includes, but is not limited to:

- ☐ weekly Seeking Safety meetings (Wednesday evenings)
- ☐ monthly appointments with your VTC probation officer – a member of the VTC team
- ☐ monthly appointments with the VJO (location appointments in Seguin, NB or SA) – a member of the VTC team, or private counselor
- ☐ community hours related to veteran programs
- ☐ specialized DWI, Drug, Anger Management type classes and/or therapy or classes relative to your particular case
- ☐ attending Veterans Treatment Court

By signing here, you have checked each of the boxes above indicating that you are stating you have read the handbook and understand the rules and consequences of the Guadalupe County Veterans Treatment Court.

_____
Signature

==========

Please type or print so it is legible.

Last Name: _____ First Name:_____ Middle Name:_____

Aliases/Maiden Name: _____ Male / Female

Email:_____ Arrest Date:_____ Inmate No.:_____

Do you have an interlock? Yes / No; If yes; please list the company:_____

Case (circle one): Felony or Misdemeanor Case No.:_____

Do you currently have an attorney? Yes / No; If yes; name:_____

Is your attorney (circle one): Hired by You – or – Court Appointed

Mobile Phone Number: _____ Alternate Phone Number: _____

Date of Birth: _____ Social Security No.:_____

Do you live in Guadalupe County? Yes / No; If no; name County of Residence:_____

Physical Address: _____

City: _____ State: Texas Zip: _____ County:_____

Mailing Address (only if different from Physical Address): _____

City: _____ State: Texas Zip: _____ County:_____

Marital Status: _____ In a relationship? Yes / No; If yes; name:_____

Who else resides in your household? _____

How many children do you have? _____ List all their names, age & name of other parent:

Name:	Age	Other Parent:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Emergency Contact Information:

Last Name: _____ First Name:_____ Relationship:_____

House Phone Number: _____ Cell Phone: _____

Physical Address: _____

City: _____ State: Texas Zip: _____ County:_____

Military Service:

Army Navy Marine Air Force Coast Guard Reserves National Guard

Dates of Service: _____ to _____

Highest Rank: _____ Rank at Discharge: _____

Type of Discharge: Honorable General Under Honorable Conditions Dishonorable

(Listed on DD214) Under Other than Honorable Conditions Bad Conduct

Where did you serve? _____

_____

_____

Did you ever serve in Combat? Yes / No - If yes, how many times?_____

Did you receive any Article 15/Disciplinary Actions/Military convictions? Yes / No

Education:

Highest level of education: ___HS Diploma ___GED ___College ___Vocational Training

Currently enrolled in education? If so, list school:_____

List all degrees or certificates:_____

_____

Driver's License:

Do you have a valid driver's license? Yes / No Is your license suspended? Yes / No

Do you an Interlock or any device? Yes / No

Driver's License No.:_____ State Issued: _____

Occupation:

Are you currently employed?: Yes / No Employer: _____

Retired?: Yes / No Retired from: _____

Work Phone: _____ Work Address: _____

Work schedule: _____

Student?: Yes / No Current School Schedule: _____

Financial Status:

Your Monthly Income: $_____ List Debts: _____

_____

List Assets: _____

_____

Substance Abuse/Mental Health/Medical:

Are you currently receiving substance abuse treatment? Yes / No

Have you ever previously received substance abuse treatment? Yes / No

Are you presently receiving mental health treatment? Yes / No

Have you ever previously received mental health treatment? Yes / No

List any existing diagnoses: _____

Are you eligible to receive services from the VA? Yes / No / Don't know

Do you currently receive any services from the VA? Yes / No

If yes, where? _____ Describe: _____

Do you have a service-connected disability? ___ Yes ___ No If so, Disability Rating_____

List Current Medications (names, dosage & how often):

Prescription name:	Dosage	Often	Taken for:	Doctor:
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Should you require additional space; please write on the back or include an additional sheet.

The Guadalupe County Veterans Treatment Court (VTC) wants to help you? So how can we help you? We are a treatment court, so during the duration of minimum 14 months of our program, you will engage in treatment so let us know what you think would benefit you.

_____

_____

_____

If you don't believe you need any help, than this is not the program for you.

Please list any arrest you have had for all non-military (State, Federal, and Local) offenses, including your current charge, with any other pending or previous charges (with the exception of traffic citations):

Date: _____ Charge: _____ Place/Location:_____

Offense: _____

Disposition: _____

==========

Date: _____ Charge: _____ Place/Location:_____

Offense: _____

Disposition: _____

Should there be additional charges; please include all by writing on the back or including an additional sheet.

Please list all military charges or arrests (For example: Article 15/Disciplinary Actions/Military related (except for traffic citations):

Date: _____ Charge: _____ Place/Location:_____

Offense: _____

Disposition: _____

Should there be additional charges; please include all by writing on the back or including an additional sheet.

If you are presently on probation or parole by another court; complete the following:

State – County: _____ _____

Probation Officer:_____ Phone No.:_____

Are you presently on bail or do you have any other outstanding criminal charges outside of Guadalupe County? _____

What are the charges and where?_____

If there are additional court actions, please include all by writing on the back or including an additional sheet.

Please check the boxes and return the following completed documents:

- ☐ **Completed Application**
- ☐ **Typed or hand-written essay/personal statement should include, but is not limited to, the following:**
  a. That you accepted full responsibility for your wrongdoing;
  b. How your disorder is connected to the events you experienced during your military service;
  c. How your disorder is related to the criminal offense for which you are charged;
  d. Your role and contributions you made to the military;
  e. Why you should be allowed the opportunity to participate in the VTC; and
  f. Any other information you want to have considered.

Participant Handbook Forms

- ☐ **a. Receipt and Review of Participant Handbook (Page 15)**
- ☐ **b. Confidentiality Statement and Agreement (Page A-4)**
- ☐ **Copy of DD214 – Member 4**
- ☐ **Copy of military identification card; if applicable**
- ☐ **VA release – as an attachment to this email**
- ☐ **VA Medical Card (White & Blue); if applicable**

By signing/submitting this application, I have read or had read to me the Guadalupe County Veterans Treatment Court description and acknowledge that if accepted, will commit the time and effort to making behavioral and life changes.

To the best of my knowledge, I have been truthful in all my answers to this application.

_____ **Date:**_____

Signature

Any additional notes you wish to include:

_____

_____

_____

_____

_____

TEXAS VETERANS COMMISSION

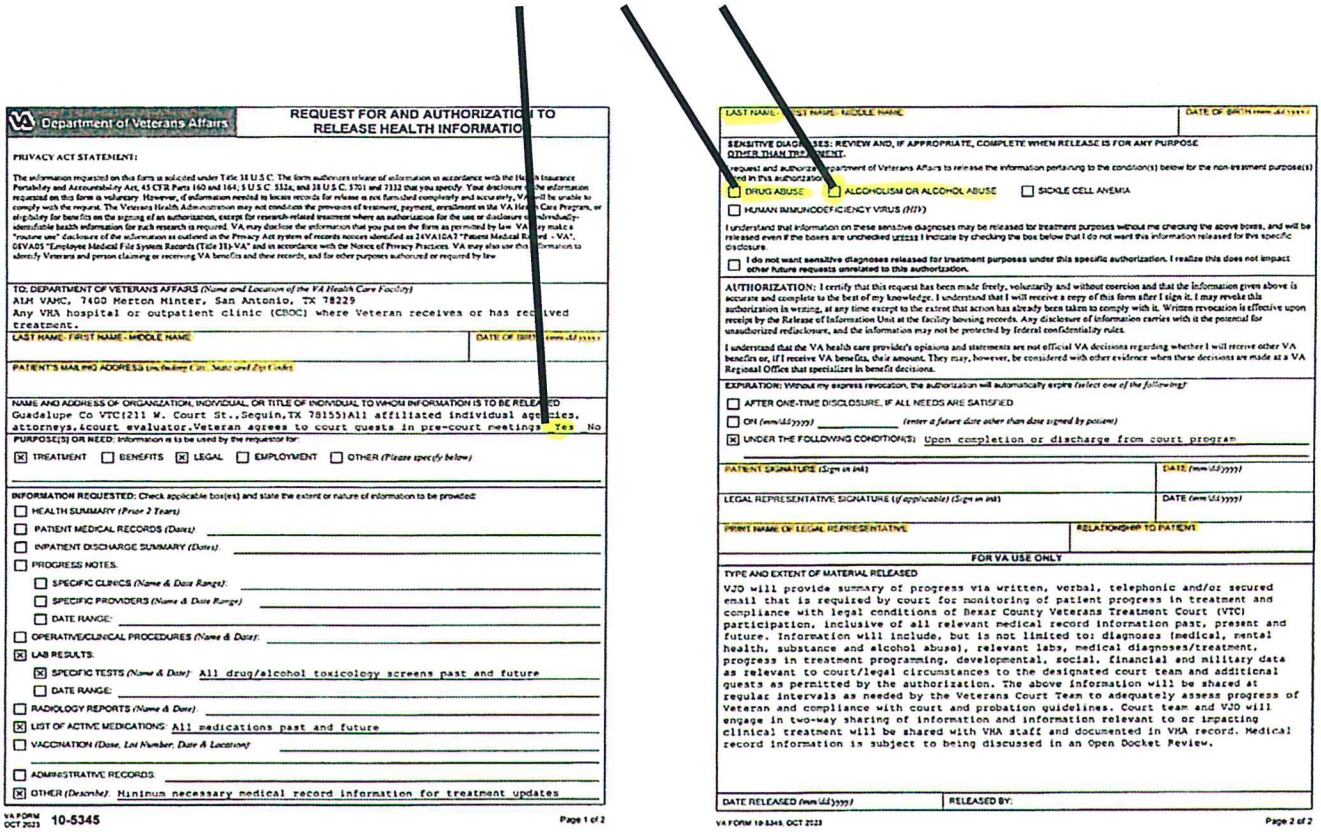
Fund for Veterans' Assistance

Helping Veterans Starts Here

The Guadalupe County Veterans Treatment Court 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. For more information, visit www.tvc.Texas.gov.

Sample instructions to please complete the attached VA Release are as follows:

- **Provide your full name, address, and DOB (on Pages 1 & 2);**
- **Sign and date (on Page 2); and**
- **Please be sure you also initial these areas as shown (do not check them):**



Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

PRIVACY ACT STATEMENT:

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 information needed 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 the provision of treatment, payment, enrollment in the VA Health Care Program, or eligibility for benefits on the signing of an authorization, except for research-related treatment where an authorization for the use or disclosure of individually-identifiable health information for such research is required. 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 24VA10A7 "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 Location of the VA Health Care Facility)*
ALM VAMC, 7400 Merton Minter, San Antonio, TX 78229
Any VHA hospital or outpatient clinic (CBOC) where Veteran receives or has received treatment.

LAST NAME - FIRST NAME - MIDDLE NAME | DATE OF BIRTH *(mm/dd/yyyy)*

PATIENT'S MAILING ADDRESS *(including City, State and Zip Code)*

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL, OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED
Guadalupe Co VTC(211 W. Court St.,Seguin,TX 78155)All affiliated individual agencies, attorneys,&court evaluator.Veteran agrees to court guests in pre-court meetings Yes No

PURPOSE(S) OR NEED: Information is to be used by the requestor for:
☒ TREATMENT ☐ BENEFITS ☒ LEGAL ☐ EMPLOYMENT ☐ OTHER *(Please specify below)*

INFORMATION REQUESTED: Check applicable box(es) and state the extent or nature of information to be provided:
☐ HEALTH SUMMARY *(Prior 2 Years)*
☐ PATIENT MEDICAL RECORDS *(Dates)*
☐ INPATIENT DISCHARGE SUMMARY *(Dates)*
☐ PROGRESS NOTES:
  ☐ SPECIFIC CLINICS *(Name & Date Range)*:
  ☐ SPECIFIC PROVIDERS *(Name & Date Range)*:
  ☐ DATE RANGE:
☐ OPERATIVE/CLINICAL PROCEDURES *(Name & Date)*:
☒ LAB RESULTS:
  ☒ SPECIFIC TESTS *(Name & Date)*: All drug/alcohol toxicology screens past and future
  ☐ DATE RANGE:
☐ RADIOLOGY REPORTS *(Name & Date)*:
☒ LIST OF ACTIVE MEDICATIONS: All medications past and future
☐ VACCINATION *(Date, Lot Number, Date & Location)*:
☐ ADMINISTRATIVE RECORDS:
☒ OTHER *(Describe)*: Minimum necessary medical record information for treatment updates

VA FORM OCT 2023 10-5345 Page 1 of 2

LAST NAME - FIRST NAME - MIDDLE NAME | DATE OF BIRTH *(mm/dd/yyyy)*

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 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 records. Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

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 *(select one of the following)*:

☐ AFTER ONE-TIME DISCLOSURE, IF ALL NEEDS ARE SATISFIED
☐ ON *(mm/dd/yyyy)* _____ *(enter a future date other than date signed by patient)*
☒ UNDER THE FOLLOWING CONDITION(S): Upon completion or discharge from court program

PATIENT SIGNATURE *(Sign in ink)* | DATE *(mm/dd/yyyy)*

LEGAL REPRESENTATIVE SIGNATURE *(If applicable)* *(Sign in ink)* | 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 and/or secured email that is required by court for monitoring of patient progress in treatment and compliance with legal conditions of Bexar County Veterans Treatment Court (VTC) participation, inclusive of all relevant medical record information past, present and future. Information will include, but is not limited to: diagnoses (medical, mental health, substance and alcohol abuse), relevant labs, medical diagnoses/treatment, progress in treatment programming, developmental, social, financial and military data as relevant to court/legal circumstances to the designated court team and additional guests as permitted by the authorization. The above information will be shared at regular intervals as needed by the Veterans Court Team to adequately assess progress of Veteran and compliance with court and probation guidelines. Court team and VJO will engage in two-way sharing of information and information relevant to or impacting clinical treatment will be shared with VHA staff and documented in VHA record. Medical record information is subject to being discussed in an Open Docket Review.

DATE RELEASED *(mm/dd/yyyy)* | RELEASED BY:

VA FORM 10-5345, OCT 2023 Page 2 of 2

Department of Veterans Affairs

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☐ PROGRESS NOTES:

- ☐ SPECIFIC CLINICS *(Name & Date Range)*:
- ☐ SPECIFIC PROVIDERS *(Name & Date Range)*:
- ☐ DATE RANGE:

☐ OPERATIVE/CLINICAL PROCEDURES *(Name & Date)*:

☒ LAB RESULTS:

- ☒ SPECIFIC TESTS *(Name & Date)*: All drug/alcohol toxicology screens past and future
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☐ ON *(mm/dd/yyyy)* _____ *(enter a future date other than date signed by patient)*

☒ UNDER THE FOLLOWING CONDITION(S): Upon completion or discharge from court program

PATIENT SIGNATURE *(Sign in ink)*	DATE *(mm/dd/yyyy)*
LEGAL REPRESENTATIVE SIGNATURE *(if applicable) (Sign in ink)*	DATE *(mm/dd/yyyy)*
PRINT NAME OF LEGAL REPRESENTATIVE	RELATIONSHIP TO PATIENT

FOR VA USE ONLY

TYPE AND EXTENT OF MATERIAL RELEASED

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DATE RELEASED *(mm/dd/yyyy)*	RELEASED BY:

Receipt and Review of Participant Handbook

Name: _____ Cause No.: _____

I, _____, acknowledge the receipt of the Guadalupe County Veterans Treatment Court Participant Handbook. By my signature below, I attest that I have been provided with a copy of the Participant Handbook and that I have reviewed it prior to agreeing to participate in the Veterans Treatment Court. Furthermore, I acknowledge that I have been made aware of the Veterans Treatment Court program rules and my responsibilities.

_____
Participant Signature

_____
Participant Printed Name

_____
Date

_____
Defense Attorney Signature

Confidentiality Statement and Agreement

I, _____, as a participant, team member, or guest of the Guadalupe County Veterans Treatment Court (VTC), duly recognize my responsibility to the confidentiality of all of the information, data and findings derived as a function of or on behalf of VTC and its activities. Accordingly, I hereby agree that:

1. Any information discussed at a VTC staffing shall remain confidential and will not be revealed or disseminated to anyone who is not a member of the VTC Team;

2. Names, addresses, contact information, and/or other identifying information of program participants shall remain confidential and will not be revealed or disseminated to anyone who is not a member of the VTC Team;

3. Unless the information reasonably relates to the commission of a new or different offense, any information garnered, obtained, or derived as a function of or on behalf of VTC and its activities shall remain confidential and will not be revealed or disseminated to anyone who is not a member of the VTC Team;

4. All information, data, and findings contained in VTC files shall remain confidential and will not be revealed or disseminated to anyone that is not a member of the VTC Team; and

5. It is understood that arrest warrants, supporting affidavits, or other information required by law to be public information or to be maintained for statistical purposes is not confidential.

Date: _____ Signed: _____

Printed Name: _____

This form is intended to comply with requirements of Title 42 of the Code of Federal Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records.