

MERCER COUNTY SPECIALTY COURTS

 Drug Treatment Court Veterans Treatment Court Mental Health Court

Only one (1) Court Selection Per Application. Mental Health Court REQUIRES MH diagnosis paperwork.

Referral and Application

Complete and submit this application along with a copy of the criminal complaint and affidavit (if available) to: Aimee Gillispie or Chris Thrasher, Specialty Courts Coordinators, Mercer County Courthouse, Mercer, PA 16137 or fax to 724-662-3880 Attn: Specialty Courts. For any questions, please call 724-662-3800 ext. 2425(Aimee) or 2431 (Chris).

REFERRAL SOURCE	
Name:	Position/Title:
Phone: ()	Email:
Relationship to Applicant:	Date of Referral:

DEFENDANT INFORMATION			
Name: <small>First Middle Last</small>			Alias: <small>(or maiden name)</small>
Physical Address: <small>Street</small>		<small>City</small>	<small>State</small>
Mailing Address: <small>Same as above <input type="checkbox"/> Street/PO Box</small>		<small>City</small>	<small>State</small>
County of Residence:		Currently Incarcerated: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Home Phone: ()		Cell: ()	Email:
Work Phone: ()		Primary language spoken: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other:	
Date of Birth:		Social Security Number:	
Race: <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Bi-racial <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Native <input type="checkbox"/> Unknown/Unreported			
Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown/Unreported			Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other
Height:	Weight:	Hair Color:	Do you have reliable transportation? <input type="checkbox"/> Yes <input type="checkbox"/> No
Possess a driver's license? <input type="checkbox"/> Yes <input type="checkbox"/> No		Status: <input type="checkbox"/> Valid <input type="checkbox"/> Suspended <input type="checkbox"/> Expired	License #:
If revoked/suspended, are you ready to regain driver's license? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Prior participation in a problem-solving court? <input type="checkbox"/> Yes <input type="checkbox"/> No			If yes, specify county:

LEGAL REPRESENTATION			
Select One: <input type="checkbox"/> Public Defender <input type="checkbox"/> Private Attorney <input type="checkbox"/> Public Defender Pending			
Attorney's Name:			Firm <small>(if private)</small> :
Address: <small>Street</small>		<small>City</small>	<small>State</small>
Phone: ()		Fax: ()	Email:

CRIMINAL/CHARGE INFORMATION

Please list all pending cases. Cases not included below will not be considered for acceptance. The addition of cases at a later date will delay the application process. You may attach an additional page if necessary.

Docket Number	Offense Tracking Number (OTN)	Offense(s)	Grade

Did you use or possess a weapon? Yes No

If yes, list:

Attach an additional page if you have more cases and/or charges. Additional page attached? Yes No

SUBSTANCE ABUSE HISTORY

Have you ever abused drugs or alcohol? Yes No

Currently abusing? Yes No

Have you ever received drug or alcohol inpatient or outpatient treatment? Yes No

If yes, where and when:

Currently in treatment? Yes No

Pharmacological interventions (medications) for substance abuse?

Yes

No

If yes, list medication(s):

(e.g., Methadone, Vivitrol, Suboxone)

Drug(s) of Choice:

1st drug of choice

2nd

3rd

Age began using drugs:

Age began alcohol use:

History of IV Drug Use? Yes No

MEDICAL/TREATMENT HISTORY

Prior psychiatric mental health inpatient/outpatient treatment? Yes No

If Yes, where and when:

Currently in mental health treatment? Yes No

Currently in mental health treatment? Yes No

If yes to the questions above, was the mental health diagnosis connected to military service? Yes No

Do you have a Mental Health Diagnosis? Yes No

If Yes, what is your diagnosis:

Pharmacological interventions (medications) for Mental Health? Yes No

If yes, list medication(s):

(e.g., Lexapro, Wellbutrin, Lithium)

Medical Insurance: Medicaid Medicare None

Private Insurance (specify):

Other (specify):

If female, are you pregnant? Yes No

If yes, indicate your due date:

List any past or present medical conditions:

EDUCATION, EMPLOYMENT, AND HOUSING STATUS			
Highest level of Education <u>completed</u> (select one):			
<input type="checkbox"/> Any grade up to 11 th	<input type="checkbox"/> GED	<input type="checkbox"/> High School Diploma	<input type="checkbox"/> Some Trade School
<input type="checkbox"/> Trade School Graduate	<input type="checkbox"/> Some College	<input type="checkbox"/> College Graduate (2 year)	<input type="checkbox"/> College Graduate (4 year)
<input type="checkbox"/> Some Post Graduate	<input type="checkbox"/> Advanced Degree		
Employment Status (select one):			
<input type="checkbox"/> Unemployed	<input type="checkbox"/> Employed Full-Time (35 or more hours/week)*	<input type="checkbox"/> Volunteer	
<input type="checkbox"/> Retired	<input type="checkbox"/> Employed Part-Time (less than 35 hours/week)*	<input type="checkbox"/> Disabled	
<input type="checkbox"/> Student Full-Time	*Specify occupation:		
Primary Source of Support (select all that apply):			
<input type="checkbox"/> Adoption Subsidy	<input type="checkbox"/> Social Security (SSI)	<input type="checkbox"/> Social Security Disability (SSD)	<input type="checkbox"/> Welfare <input type="checkbox"/> None
<input type="checkbox"/> Foster Care Subsidy	<input type="checkbox"/> Retirement Plan	<input type="checkbox"/> Workers Compensation	<input type="checkbox"/> Family <input type="checkbox"/> Other
<input type="checkbox"/> Unemployment	<input type="checkbox"/> Veterans Benefits	<input type="checkbox"/> Salary/Wages	<input type="checkbox"/> Disability
Housing Status (select one): <input type="checkbox"/> Independent <input type="checkbox"/> Dependent (<i>incarcerated, with friends, etc.</i>) <input type="checkbox"/> Homeless			

FAMILY/CHILDREN INFORMATION			
Living Arrangements:	<input type="checkbox"/> Single	<input type="checkbox"/> Separated	<input type="checkbox"/> Widowed
	<input type="checkbox"/> Married*	<input type="checkbox"/> Divorced	<input type="checkbox"/> Living Together*
*Name of spouse or partner:			
# of Children:	# of Dependent Children:	Custody of all minor children: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
Visitation rights for all children not residing with you? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A			Child support amount: (if applicable)
Currently have contact with your primary family? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A			\$ per month

MILITARY HISTORY			
Have you (defendant) ever been in the military? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please answer the questions below.</i>			
Branch:	Enlistment Date:	Years of Service:	
Discharge Type (select one):			
<input type="checkbox"/> Still serving	<input type="checkbox"/> Dishonorable	<input type="checkbox"/> Clemency	<input type="checkbox"/> Other than honorable <input type="checkbox"/> General (<i>includes medical</i>)
<input type="checkbox"/> Honorable	<input type="checkbox"/> Bad Conduct	<input type="checkbox"/> Dismissal	<input type="checkbox"/> Entry level separation
Discharge Date:	Rank at Discharge:		
Any criminal convictions prior to military service? <input type="checkbox"/> Yes <input type="checkbox"/> No		Incarcerated while in military? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Deployed abroad: <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, specify where:		
Military combat: <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, specify the number of deployments to combat zones:		
Conflict Era of Service (select all that apply):			
<input type="checkbox"/> Korea	<input type="checkbox"/> ODS (<i>Iraq/Kuwait 1990-2003</i>)	<input type="checkbox"/> OIF (<i>Iraq 2003-2010</i>)	
<input type="checkbox"/> Vietnam	<input type="checkbox"/> OEF (<i>Afghanistan 2001-present</i>)	<input type="checkbox"/> OND (<i>Iraq 2010-present</i>)	
Diagnosed with (select all that apply): <input type="checkbox"/> PTSD <input type="checkbox"/> TBI <input type="checkbox"/> MST			Eligible for VA Benefits: <input type="checkbox"/> Yes <input type="checkbox"/> No

DO NOT COMPLETE THIS SECTION - OFFICIAL COORDINATOR USE ONLY		
<i>Date(s) Distributed for Review</i>		
DA:	TX/VJO:	R/N: