STATE OF MICHIGAN COUNTY OF MACOMB 16TH JUDICIAL COURT	16TH JUDICIAL CIRCUIT TREATMENT COURT APPLICATION	**ALL** CIRCUIT COURT CASE #S:
		JUDGE:

PEOPLE OF THE STATE OF MICHIGAN V.	Defendant:
	Defense Counsel Name: Defense Counsel Phone Number:

Next Court Date: _____

Candidate is: ☐ Incarcerated ☐ On Bond	
Current Case(s) Charge(s): Sentencing Guidelines:	
Is there a victim in this matter? ☐ Yes ☐ No	Victim's relationship to the defendant:
Have you ever participated in a Drug Court, Sobriety Court, Mental Health Court or Veteran's Court before? ☐ Yes ☐ No When did you participate? Where did you participate?	
List all open case(s) in other courts (including any outstanding warrants)	
Do you have any assaultive charges or CSC charges on your criminal history: ☐Yes ☐No If yes, please list charges:	

DEMOGRAPHIC INFORMATION (All Fields Required):

GENDER: ☐Male ☐Female

Address:	DOB:	Cell Phone:
City:	Zip:	Email address:

CURRENT LIVING SITUATION:

☐ Own Home/Apartment ☐ Sober Living ☐ Other _____

☐ With a Friend/Relative ☐ Homeless

Are you a US Citizen? ☐Yes ☐No Last 4 of Social Security Number: _____

MILITARY:

Have you ever served in the United States Military? ☐Yes ☐No	Service Start Date:
	Service End Date:

Branch of Service:

☐ Air Force ☐ Coast Guard ☐ Navy

☐ Army ☐ Marines ☐ Reserves

Combat Deployment? ☐Yes ☐No	Location:

Current Military Status:

☐ Active ☐ General Under Other Than Honorable Conditions

☐ Honorable Discharge ☐ Dishonorable or Bad Conduct Discharge:

☐ General Under Honorable Conditions

Are you eligible for VA benefits/services? ☐Yes ☐No

PHYSICAL HEALTH:

Do you have any current medical conditions? ☐Yes ☐ No

Please describe:_____

Are you able to participate in our program with these conditions? ☐Yes ☐No

Do you have any physical limitation(s)? ☐Yes ☐No If yes: _____

If yes, are you able to participate in our program with this limitation(s)? ☐Yes ☐No

Do you have Medicaid coverage? ☐Yes ☐No	Do you have any other health insurance? ☐Yes ☐No

Are you currently taking ANY medications? ☐ Yes ☐No Please describe all medications including over the counter medications and herbal supplements:_____

_____

MENTAL HEALTH:

Have you ever had a mental health diagnosis? ☐Yes☐ No If yes, please describe:

_____

Have you ever attended treatment for a mental health issue?☐ Yes ☐No If yes, please describe where and when: _____

Are you currently taking ANY medications for mental health issues? ☐Yes ☐No If yes, please described ALL medications including over the counter and herbal supplements:

_____

Do you have a guardian? ☐ Yes ☐ No

If Yes, Name or Agency _____ Phone: _____

SUBSTANCE ABUSE:

Have you ever abused alcohol or other drugs? ☐Yes ☐No If yes, what substances (check all that apply):

☐ Alcohol	☐ Crack Cocaine	☐ Methadone
☐ Amphetamines	☐ Heroin	☐ Suboxone
☐ Benzodiazepine	☐ Opiate (Other)	☐ Methamphetamines
☐ Cocaine	☐ Marijuana	☐ Other _____

Have you ever abused prescription medications? ☐Yes ☐ No

If yes, describe: _____

How long have you abused alcohol or other drugs? _____

Do you acknowledge that you abuse or are dependent on alcohol or drugs? ☐Yes ☐ No

ABILITY TO MEANINGFULLY PARTICIPATE:

Do you have reliable transportation or bus availability to attend any or all of the following: mental health or substance abuse treatment, alcohol/drug testing, probation reporting, up to weekly reports to the Court, case management sessions with the coordinator and regular attendance at a self-help support program?

☐ Yes ☐ No

What are the most important areas you would like to address or improve on in a treatment court setting?

_____

_____

_____

ACKNOWLEDGEMENT:

I understand that this information is intended to be used for eligibility into one of the Specialty Court Treatment Courts. It does not guarantee my acceptance into the program. Furthermore, I understand that the demographic information contained on this form (including ethnicity and race) will be used for statistical reporting purposes only and will not affect my eligibility.

Defendant's Signature:	Defense Counsel Signature:
Approved by Judge: (signature here or entered in CourtView docket)	Date of Application:

This application will be considered for all specialty court programs at the 16th Judicial Circuit Court. If the defendant is not eligible for a Circuit Court program and the Judge approves, this application could be forwarded to an appropriate District Court program for consideration there.

RETURN COMPLETED FORM TO THE SPECIALTY COURT DEPARTMENT

~~In person: 6th floor, Court building~~

~~Fax: (586) 783-8179~~

Email: treatmentcourts@macombgov.org