



Montgomery County Treatment Court Application

Fields Marked with a * are required. Information from this form will not be SAVED.

* Please checkmark to confirm you understand this Disclaimer.

I AM MAKING AN APPLICATION/REFERRAL TO THE FOLLOWING TREATMENT COURT
{Please Select One):

| | |
|-------------------------------|-----|
| Status (always NEW initially) | New |
|-------------------------------|-----|

DEPENDENT INFORMATION:

| | | |
|--------------------|---------------------|-------------------------|
| * CLIENT LAST NAME | * CLIENT FIRST NAME | * CLIENT MIDDLE INITIAL |
| | | |

| | |
|---------------------------------|----|
| Aliases-Maiden Name | |
| *Date of Birth | |
| Docket Number | |
| Inmate Number | |
| * Current Phone Number | |
| * Current Street Address | |
| * Current City | |
| * Current State | PA |
| * Current Zip Code | |
| * Current County | - |
| Permanent (last known) address: | |
| * Sex | |

WHO ELSE RESIDES IN YOUR HOUSEHOLD?

PLEASE LIST IF ASSIGNED:

| Type | Name | Phone | Email Address |
|-------------------|------|-------|---------------|
| Probation Officer | | | |
| Prison Caseworker | | | |
| Judge | | | |
| Attorney | | | |

| | |
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| IS COMPETENCY AN ISSUE? | - |
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ISSUES SURROUNDING REQUEST:

| | |
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| (CHECK ALL THAT APPLY) | Drugs Alcohol Mental Health |
|------------------------|-----------------------------------|

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|--|---|
| | Sexual Issues Abuse Medical Reasons Anger Housing Placement |
| Briefly explain Issues checked: | |
| History of Trauma? | - |
| Trauma History | |
| Mental Health Crisis | - |
| Mental Health explanation | |
| <u>EMERGENCY CONTACT INFORMATION:</u> | |
| Name | |
| Address | |
| Phone-Home | |
| Phone-Cell | |
| <u>MILITARY SERVICE (if applicable):</u> | |
| Have you ever served in the Military? | - |
| If yes, what were your dates of service? | |
| What Branch of the military did you serve? | - |
| Where did you serve? | |
| What was your Rank? | |
| What was your Military Discharge? | |
| Did you serve in Combat? | - |
| <u>EDUCATION:</u> | |
| Highest level of Education completed: | - |
| <u>DRIVERS LICENSE:</u> | |
| Do you have a valid driver's license? | - |
| If yes, Operator's License State and Number | |
| <u>OCCUPATION:</u> | |
| <u>CURRENT EMPLOYER(S):</u> | |
| <u>FINANCIAL STATUS: (Other Financial Debts and Assets)</u> | |
| <u>PERSONAL INFORMATION:</u> | |
| Marital Status | - |
| In Relationship | - |
| If yes with whom | |
| Relationship Age | |
| Relationship Address | |
| Relationship in recovery | - |
| How many Children do you have | |
| List children (Name-Age/Address/Name of other parent): | |
| <u>MEDICAL DATA (if applicable):</u> | |
| Do you have a Severe Mental Illness (SMI)? | - |
| If yes, select all that apply: | Major Mood Disorder |

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| | Schizophrenia Psychosis NOS PTSD Borderline Personality Disorder Bi-Polar Disorder |
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| Is there a Psychiatric Evaluation (completed within last 6 months is required for consideration)? IF YES, check box and fax to 610-555-1234 or, Email as attachment to: Bhav@montcopa.org | |
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| AXIS I Diagnosis | |
| Treating Psychiatrist | |
| Current Medications: | |

[CASE MANAGER INFORMATION \(if applicable\)](#)

| | |
|---|--|
| NAME: | |
| AGENCY: | |
| ADDRESS: | |
| PHONE #: | |
| Where have you attended treatment: (please list all inpatient, outpatient facilities and halfway houses): | |
| Substance Abuse (list the drug, frequency, and last date of use) : | |

If you are presently on probation or parole complete the following:

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|--|---|
| State - County | |
| Probation Officer name | |
| Assigned Judge | |
| Are you presently on bail or do you have any other outstanding criminal charges outside of Montgomery County? | - |
| What are the charges and where? | |
| Where do you think you would be in life (career, family, employment, etc,...) if you had never had a substance abuse or mental health issue? | |
| What are your future goals? | |
| What do you think has lead to your most recent involvement in the criminal justice system? Any traumatic life events? | |
| Why are you applying for a Treatment Court? | |

By signing/submitting this application, I have read or had read to me the Treatment Court description and acknowledge that I will commit my time and effort to create in me behavioral and life change if accepted. I have been truthful, to the best of my knowledge, with regard to all my answers in this application.

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| Signed/Submit Date | |
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If you have any questions as to the program you are applying for, please read the policy and procedure manual on our web page.

**IN THE COURT OF COMMON PLEAS OF MONTGOMERY COUNTY, PENNSYLVANIA
CRIMINAL DIVISION**

RULE 600 WAIVER DUE TO TREATMENT COURT APPLICATION

| | |
|------------------------|--|
| NAME: | |
| DOCKET No. (s): | |

I understand that under Rule 600 of the Pennsylvania Rules of Criminal Procedure my trial in Montgomery County Court must begin on or before the 180th day from the filing of the Criminal Complaint if I am incarcerated. I understand that my trial must begin on or before the 365th day from filing of the Criminal Complaint if I am not incarcerated. I further understand that the charges against me may be dismissed if my trial does not commence within the time allowed under Rule 600.

I understand that by filing an application for acceptance into a Treatment Court program, I am requesting that my case be removed from normal scheduling of my criminal case(s) in the Montgomery County Court of Common Pleas, so that it may be considered for Treatment Court. I further understand that my Treatment Court Application may delay my case being brought to trial, should my application be denied. I understand that time will be required to review my case and to procure necessary information and materials.

I hereby waive my speedy trial rights under Rule 600 from the time I submit my Treatment Court Application until either: 1.) I am admitted into a Treatment Court program or 2.) Until the first available court listing after my Treatment Court Application has been denied or withdrawn.

I have not been made any promises, nor have I been forced to sign this waiver. I read and write the English language, or this waiver has been explained to me in a language that I understand.

Signature of Defendant

Date

Please checkmark to confirm you understand this represents your electronic signature.

If you need further assistance, please contact the following program coordinator:

DRUG TREATMENT COURT: Megan Morrison, 610-992-7773, mmorrison@montcopa.org

BEHAVIORAL HEALTH COURT: Kasey Lauro, 610-992-7449, klauro@montcopa.org

VETERANS TREATMENT COURT: Kasey Lauro, 610-992-7449, klauro@montcopa.org