

WAYNE COUNTY DRUG AND TREATMENT COURT

Referral and Application

Complete and submit this application along with a copy of the criminal complaint and affidavit to:
Jonathan J. Dunsinger, Drug and Treatment Court Coordinator, Wayne County Courthouse, 925 Court Street, Honesdale, PA 18431. Email: jdunsinger@waynecountypa.gov Phone: 570-253-5970 ext. 2306

DEFENDANT INFORMATION			
Name:		Alias:	
<i>First</i>	<i>Middle</i>	<i>Last</i>	<i>(or maiden name)</i>
Physical Address:			
<i>Street</i>	<i>City</i>	<i>State</i>	<i>Zip Code</i>
Mailing Address:			
<i>Same as above</i> <input type="checkbox"/>	<i>Street/PO Box</i>	<i>City</i>	<i>State</i>
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	OLN:
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 (if private):	
Address:			
<i>street</i>	<i>city</i>	<i>state</i>	<i>Zip Code</i>
Phone: ()		Fax: ()	Email:

CRIMINAL/CHARGE INFORMATION

Please list all pending cases in any jurisdictions. Be sure to provide a complete list. The addition of cases at a later date will delay the process. Attach additional pages if necessary.

Docket Number	Offense Tracking Number (OTN)	Offense(s)	Grading	Was a weapon involved?

Attach an additional page if you have more pending cases. Additional page attached? Yes No

SUBSTANCE ABUSE HISTORY

Have you ever abused drugs or alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No		Currently abusing? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever received inpatient or outpatient drug or alcohol treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No		Currently in treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Drug(s) of Choice:	1:	2:	3:
Age began using drugs:	Age began alcohol use:	History of IV drug use? <input type="checkbox"/> Yes <input type="checkbox"/> No	

MEDICAL/TREATMENT HISTORY

Prior mental health inpatient or outpatient treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No		Currently in mental health treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes to the questions above, was the mental health diagnosis connected to military service? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Pharmacological interventions (medications) for Substance abuse? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, list medications: (e.g., Methadone, Vivitrol, Suboxone)	
Medical Insurance: <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> None <input type="checkbox"/> Private Insurance (specify):			
If female, are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, indicate your due date:	
List any past or present medical conditions:			
List any medications you are taking:			

EDUCATION, EMPLOYMENT AND HOUSING STATUS

Highest level of education completed (select one):

- Any grade up to 11th GED High School Diploma Some Trade School
 Trade School Graduate Some College 2 year College Degree 4 year college degree
 Some Post Graduate Advanced Degree

Employment Status (select one):

- Unemployed Employed Full-Time (35 hrs/week or more)* Volunteer
 Retired Employed Part-Time (less than 35 hrs/week)* Disabled
 Student Full-Time *Specify Occupation:

Primary Source of Support (select all that apply):

- Adoption Subsidy Social Security (SSI) Social Security (SSD) Welfare None
 Foster Care Subsidy Retirement Plan Workers Compensation Family Other
 Unemployment Veterans Benefits Salary/Wages Disability

Housing Status (select one): Independent Dependent (incarcerated, friends, etc.) Homeless

FAMILY/CHILDREN INFORMATION

Living Arrangements: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Living Together	Name of spouse or partner:
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# of children:	# of dependent children	Custody of all minor children: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
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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:
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Do you have contact with your primary family? <input type="checkbox"/> Yes <input type="checkbox"/> No	\$ per month
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MILITARY HISTORY

Have you ever served in the military? Yes No *If yes, please answer the questions below.*

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 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 number of deployments to combat zones:	
Conflict Era of Service (select all that apply): <input type="checkbox"/> Korea <input type="checkbox"/> Vietnam <input type="checkbox"/> ODS <i>(Iraq/Kuwait 1990-2003)</i> <input type="checkbox"/> OEF <i>(Afghanistan 2001-present)</i> <input type="checkbox"/> OIF <i>(Iraq 2003-2010)</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 USE ONLY

Date application received:	Received by:
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