

**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:  
 Melinda Card, Drug and Treatment Court Coordinator, Wayne County Courthouse, 925 Court Street,  
 Honesdale, PA 18431. Email: mcard@waynecountypa.gov Phone: 570-253-5970 ext. 2006

<b>DEFENDANT INFORMATION</b>				
Name:			Alias:	
First	Middle	Last	(or maiden name)	
Physical Address:			City	State
Street			Zip Code	
Mailing Address:			City	State
Same as above <input type="checkbox"/> Street/PO Box			Zip Code	
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:	

<b>LEGAL REPRESENTATION</b>				
Select One: <input type="checkbox"/> Public Defender <input type="checkbox"/> Private Attorney <input type="checkbox"/> Public Defender Pending				
Attorney's Name:		Firm ( <i>if private</i> ):		
Address: street		city	state	Zip Code
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?
<i>Attach an additional page if you have more pending cases. Additional page attached? <input type="checkbox"/> Yes <input type="checkbox"/> No</i>				
<b>Do you have any cases pending in our court such as a PFA, custody, divorce or civil matter?</b> <input type="checkbox"/> Yes <input type="checkbox"/> 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:  Single  Married  Separated Name of spouse or partner:

Divorced    Widowed    Living Together

Name of spouse or partner:

# of children:

### # of dependent children

Custody of all minor children:  Yes  No  N/A

Visitation rights for all children not residing with you?  Yes  No  N/A Child support amount:

Do you have contact with your primary family?  Yes  No \$6 per month

### 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):

Still Serving  Dishonorable  Clemency  Other than Honorable  General *(includes medical)*  
 Honorable  Bad Conduct  Dismissal  Entry Level Separation

Discharge Date:	Rank at Discharge:
-----------------	--------------------

Any convictions prior to military service?  Yes  No Incarcerated while in military?  Yes  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):  Korea  Vietnam  ODS *(Iraq/Kuwait 1990-2003)*

OEF *(Afghanistan 2001-present)*  OIF *(Iraq 2003-2010)*  OND *(Iraq 2010-present)*

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:
----------------------------	--------------