Docket
Number(s) _____

_____

Bucks County Drug Court Program Application

Please read each question carefully before answering. Failure to complete all required Drug Court forms and questionnaires accurately will delay the processing of your application. False or misleading information will be treated as a false statement subjecting you to exclusion from the Program. Drug Court needs the information requested to be able to review your needs and ensure that Drug Court could address these needs to better support your recovery.

Background Information:

Full Name: _____

Maiden Name /Alias(es): _____

Sex: ☐ Male ☐ Female

Home Address: _____
Street Apartment Number

_____
City State Zip Code

Phone Numbers: Home _____ Cell _____ Work _____

Social Security Number: _____

Date of Birth: _____ Place of Birth: _____
(City, State)

Are you a citizen of the United States? ☐ YES ☐ NO

Are you a veteran? ☐ YES ☐ NO

Race: ☐ White ☐ Black ☐ Asian ☐ American Indian or Alaskan Native

☐ Native Hawaiian or other Pacific Islander

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Emergency Contact: _____ Relationship: _____

Address: _____
Phone Numbers: Home _____ Cell _____

Housing:

With whom do you currently reside or if incarcerated, with whom do you plan to reside?

Name	Relationship	Does he/she have a Criminal Record? If so, what are the charges?	Does this person use alcohol or other substances?

List your residences within the past ten (10) years:

Address	Roommate(s)

Education:

Highest level of education completed (check all that apply):

☐ Less than 11th grade ☐ High School Grad ☐ Technical School
☐ GED ☐ Some College ☐ Associate Degree ☐ Bachelor's Degree

☐ Check here if you need help obtaining a GED.

Name of High Schools attended: _____

_____

Have you been suspended and/or expelled from school? If so, why? _____

_____

What are your plans for education? _____

Do you speak, read and write the English language? ☐ YES ☐ NO

Have you ever been told by any teachers/school you needed to attend special classes? ☐ YES ☐ NO
If so, did you have an individual education plan (IEP) ☐ YES ☐ NO

Transportation:

What is your means of transportation? ☐ Own car ☐ Family Member ☐ Public transportation

Do you have a valid driver's license? ☐ YES ☐ NO

If YES, Operator's License Number: _____
If NO, what is the status of your driver's license: ☐ Suspended ☐ Expired

Employment:

Current employment status: ☐Unemployed ☐Part-time ☐ Full-time ☐ Retired ☐ Disabled

List all employment during the past three (3) years. Use additional sheets if necessary.

Employer	Address	Phone #	Supervisor	Dates

Do you need Job Training and/or help with your resume? ☐ YES ☐ NO

Financial Status:

Debts		Assets	
Item	**Amount**	**Item**	**Amount**

Marital Status/Children:
☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
Other: _____

Are you presently involved in a relationship? ☐ YES ☐ NO

If YES, Name: _____ Date of Birth: _____

Address: _____

Is he/she in recovery? ☐ YES ☐ NO

Is he/she currently on probation or parole? ☐ YES ☐ NO

If YES, where? _____

For what crime(s)? _____

Do you have any children/How many/Ages _____

Do you have custody of your children? ☐ YES ☐ NO

If no, who has custody of your children? _____

Is there a custody order regarding your children? ☐ YES ☐ NO
If YES, in what County? _____

Is there/has there been Children and Youth involvement? ☐ YES ☐ NO
Name of CYS worker _____

Insurance Information:
What is the name of your Health Insurance Company? _____

Insurance Policy Number _____

Representation by Counsel:

Are you represented by counsel? ☐ YES ☐ NO

If YES, Counsel's Name: _____

Counsel's Address: _____

Counsel's Phone Number: _____

Prior Contact(s) with the Criminal Justice System:

Have you ever been arrested, charged, convicted/adjudicated, cited (including Vehicle Code violations) or held by any law-enforcement or juvenile authorities in the United States regardless of whether the citation or charge was dropped or dismissed or you were found not guilty or whether the record has been "sealed," expunged, or otherwise stricken from the court records on any occasion other than this arrest?
☐ YES ☐ NO

If YES, complete the attached Criminal History & Incarceration Questionnaire on page 11

Do you have any prior convictions for violent offense(s)? ☐ YES ☐ NO
Violent offenses include, but are not limited to, the following offenses: Third Degree Murder, Voluntary Manslaughter, Aggravated Assault, Simple Assault, Terroristic Threats, Rape, Involuntary Deviate Sexual Intercourse, Aggravated Indecent Assault, Incest, Sexual Assault, Arson, Kidnapping, Burglary (of a structure adapted for overnight accommodation and at the time of the offense any person is present), and Robbery.

Have you ever been incarcerated, for any period of time for any reason? ☐ YES ☐ NO

If YES, complete the attached Criminal History & Incarceration Questionnaire on page 11.

Are you currently incarcerated? ☐ YES ☐ NO
If YES, date of detention: _____

Are you presently on probation or parole? ☐ YES ☐ NO

If YES, where and who is your Probation Officer (P.O.)?
State/County: _____

P.O.'s Name: _____

Are you presently on bail for a new case, including the one you are making application to Drug Court, or do you have any other outstanding criminal charges, including summary offenses in or outside of Bucks County? ☐ YES ☐ NO
If Yes, please explain: _____
_____

Medical History:
List any medical problems/diagnoses/disabilities and treatment/medications you have had in the past 3 years:

Date	Problem/Diagnosis	Treatment	Medications

List any hospitalizations, including overdoses, in the past 3 years:

Date	Problem	Treatment	Medications

List any prescribed or over the counter medications for physical health issues that you are taking **now:**

Medication	Physical Health Issue	Name of prescribing doctor

List any prescribed medications for physical health issues that you have taken in the **past 3 years:**

Date last taken	Medication	Physical Health Issue	Name of prescribing doctor

Have you ever had lost of consciousness? Please include overdoses. ☐ YES ☐ NO
Please describe circumstances surrounding event:_____
_____

Have you had a traumatic brain injury? ☐ YES ☐ NO
Please describe circumstances surrounding event:_____
_____

Mental Health History:
Are you currently experiencing any mental health symptoms ☐ YES ☐ NO

If so, what are your symptoms?_____

Are you receiving treatment for these symptoms? ☐ YES ☐ NO

If yes, please complete the following:
Current Doctor/Treatment provider: _____

Date of last appointment attended: _____

What type of treatment (inpatient/outpatient): _____
Diagnosis:_____

List any mental health medications you are currently taking:

Current Medication	Dosage	Date Last Taken	Prescribing Doctor

Have you experienced any mental health symptoms in the past? ☐ YES ☐ NO
If so, what were your symptoms?_____

Have you received treatment in the past for these symptoms? ☐ YES ☐ NO
If yes, please complete the following regarding your previous mental health treatment history:

Date of Treatment	Provider	Specify inpatient/outpatient	Diagnosis	Medications

Substance Abuse History:
When was your first use of drugs or alcohol (age and specifics) and what led to your use?

_____

_____

_____

_____

What is your drug/alcohol use history? Use additional sheets if necessary.

Substance	Frequency	Amount	At What Age?	Date of Last Use

Are you currently in treatment for a Drug and Alcohol problem? ☐ YES ☐ NO

If yes, complete the following:
Doctor/Treatment provider: _____
Date of last appointment attended: _____
Level of Care: _____
Diagnosis: _____
Are you being prescribed methadone, suboxone or vivitrol? ☐ YES ☐ NO
If yes, what and when was last dose? _____

Have your tried methadone, suboxone or vivitrol in the past and if so, describe your experience with medication: _____

_____

_____

Have you engaged in Twelve Step meetings (AA, NA, etc.)? ☐ YES ☐ NO

If YES, do you have a sponsor? ☐ YES ☐ NO
Do you have a Home Group? ☐ YES ☐ NO
If YES, name of Home Group: _____

What is your longest period of sobriety and how did you maintain it? _____

_____

Have you had or been in any treatment/hospitalizations/detox/rehab for drug and/or alcohol use?

☐ YES ☐ NO If yes, please complete the following:

What is your substance abuse treatment history? Use additional sheets if necessary.

Facility	Level of care	Dates	Completed Successfully? How long were you abstinent

List individuals that are a positive influence in your life:

Name	Relationship	Address	Phone #

How would you describe your childhood? For example: healthy, chaotic, abusive. Is there anything about your childhood you feel important Drug Court should be aware of so proper treatment can be recommended? If so, please explain below.

Have you ever been asked to attend anger management therapy or experienced anger which led you to hurt someone, yourself, or destroy property? If so, explain circumstances.

ACKNOWLEDGMENT OF BANNED SUBSTANCES

The following medications and other substances are not allowed:

Alcohol
Amineptine
Amitriptyline
Amitriptylinoxide
Amoxapine
Barbiturates and Tramadol
Benzodiazepines such as Ativan, Valium, Xanax, Klonopin, etc.
Butripyline
Clomipramine
Demexiptiline
Desipramine
Dibenzepin
Dimetacrine
Dosulepin
Doxepin
Imipramine
Imipraminoxide
Iprindole
Kava
Kombucha
Kratom
Lofepramine
Medical Marijuana
Melitracen
Metapramine
Methadone and Suboxone are permitted only if prescribed as part of your treatment and recovery plan and if approved by the Drug Court Team
Muscle Relaxers
Narcotic pain medication such as Percocet, Darvocet, Oxycontin, etc.
Nitroxaepine
Nortriptyline
Noxiptiline
Opipramol
Pipofezine
Protriptyline
Quinupramine
Sleep Aids such as Ambien or Soma
Stimulants such as Adderall or Ritalin
Tianeptine
Tramadol
Trimipramine

The following medications cause a cross-reaction with drug testing and alternatives should be prescribed: Clarithromycin, Effexor, Lamictal, Protonix, Sustiva, Zantac, Zoloft

- Energy Drinks, Poppy Seeds, Morning Glory Seeds, Salvia, Weight Loss Aids
- K2, bath salts, spice, synthetic marijuana, inhalants, and other mood altering or hallucinogenic substance are strictly prohibited.

- I have reviewed the list of banned substances. I understand I cannot use any of these substances and further understand I am subject to sanctions and possible termination should I ingest any of these substances.

Signature _____

Date _____

- I am currently prescribed _____ and wish to petition the Court to continue using this substance while in the Program. I have attached a letter from my primary care professional stating he/she is aware of my addictive history and feel this is the best substance to prescribe currently. I have also attached my most recent psychiatric evaluation supporting the use of this substance.

Signature _____

Date _____

Why are you applying for Drug Court?

_____
_____
_____
_____
_____
_____
_____
_____
_____

By signing, I have read or had read to me the Drug Court Program description and acknowledge that I will commit my time and effort to create in me behavioral and life changes if accepted into Drug Court. I have been truthful, to the best of my knowledge, with regard to all my answers in this application, and if applicable, the attached Criminal History & Incarceration Questionnaire.

_____ _____
Signature Date

_____ _____
Attorney Signature Date

_____
Attorney (Print Name)

Criminal History & Incarceration Questionnaire

List **ALL** prior convictions and prior periods of incarceration. Include any prior conviction(s) you have- even if you were not incarcerated on that case. Also, include any period of incarceration related to child/spousal support and Protection From Abuse (PFA) contempt matters. Use as many copies of this form as necessary.

1. Criminal Offense(s): _____
   Docket Number(s): _____
   Date(s): _____
   Prison: _____

2. Criminal Offense(s): _____
   Docket Number(s): _____
   Date(s): _____
   Prison: _____

3. Criminal Offense(s): _____
   Docket Number(s): _____
   Date(s): _____
   Prison: _____

4. Criminal Offense(s): _____
   Docket Number(s): _____
   Date(s): _____
   Prison: _____

5. Criminal Offense(s): _____
   Docket Number(s): _____
   Date(s): _____
   Prison: _____

6. Criminal Offense(s): _____
   Docket Number(s): _____
   Date(s): _____
   Prison: _____

FOR OFFICIAL USE ONLY:

Date Application Submitted to Drug Court Coordinator:
Date Application Referred from Coordinator to District Attorney for Approval:
Date Application Referred from Coordinator to Treatment Coordinator for Approval:
Approved by District Attorney: ☐ YES ☐ NO Date: If NO, explanation:
Recommended Sentence if Terminated/Fails to Complete Drug Court Program:
District Attorney's Agreement (if any) for Successful Completion of Drug Court Program:
Date Referred for Drug and Alcohol Assessment: Assessment Referred to:
Date of Assessment: Assessment Completed by:
Date/Time Scheduled to Observe Drug Court Program:
Date/Time Scheduled to Start Drug Court Program: