



OFFICE OF THE FOREST COUNTY DISTRICT ATTORNEY
FOREST COUNTY COURT HOUSE
526 ELM STREET
TIONESTA, PENNSYLVANIA 16353
Phone: 814-755-3164

DRUG COURT APPLICATION

Drug Court is a post plea program. The Drug Court will screen and assess applicants who are charged with crimes that are drug/alcohol addiction driven. You must agree to placement in Drug Court and be a resident of Forest County.

An individual with multiple pending cases will not be automatically excluded from consideration from placement in Drug Court. Offenders facing parole or probation revocation for DUI/drug related violations are also eligible for placement in Drug Court.

If you are charged with or have ever been convicted of any of the following offenses, you are excluded from consideration: Homicide, Burglary, Robbery, Kidnapping, Aggravated Assault, Weapons Possession in the commission of an offense, Sexual offenses, Arson.

The District Attorney's Office by law cannot give any advice to any person seeking admission to Drug Court. Do not, under any circumstances, telephone or stop by the District Attorney's Office for help in filling out the application. Please forward all questions to your attorney. If you do not have an attorney and find it absolutely necessary to communicate with the District Attorney's Office, please write a letter and we will reply, if appropriate.

You should review the Drug Court policies and procedures handbook prior to submitting your application.

You are advised that any false statement made with intent to mislead the District Attorney's Office or the Court is a misdemeanor of the second degree punishable by a fine of up to \$5,000 and/or imprisonment up to two (2) years.

Please fill out the following application completely, making sure to provide all past treatment information.



**REGIONAL DRUG COURT (RDC)
Forest County
Referral and Application**

Complete and submit this application along with a copy of the criminal complaint and affidavit (if available) by mail, fax, or email to: Linda E. Critzer, District Court Administrator, Warren-Forest Counties, 204 Fourth Avenue, Warren, PA 16365: lcritzer@warren-county.net; fax: (814) 728-3452

REFERRAL SOURCE	
Name:	Position/Title:
Phone: ()	Email:
Relationship to Applicant:	Date of Referral:

DEFENDANT INFORMATION			
NAME:			Alias:
First	Middle	Last	(or maiden name)
Physical Address:		City	State Zip Code
Street			
Mailing Address:		City	State Zip Code
Same as above <input type="checkbox"/> Street/PO Box			
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"/> White <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Bi-racial <input type="checkbox"/> Black <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	License #:
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:		City	State Zip Code
Street			
Phone: ()		Fax: ()	Email:

CRIMINAL/CHARGE INFORMATION

Please list all pending cases. Cases not included below will not be considered for acceptance. The addition of cases at a later date will delay the application process. You may attach an additional page if necessary.

Docket Number	Offense Tracking Number (OTN)	Offenses (s)	Grade
Did you use or possess a weapon? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, list:	
Attach an additional page if you have more cases and/or Charges. Additional pages attached? <input type="checkbox"/> Yes <input type="checkbox"/> No			

SUBSTANCE ABUSE HISTORY

Have you every 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 drug or alcohol inpatient or outpatient treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No			Currently in Treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No
List past or current inpatient/outpatient treatment for drugs or alcohol:			
<input type="checkbox"/> Drugs <input type="checkbox"/> Alcohol	Place:	Year:	
<input type="checkbox"/> Drugs <input type="checkbox"/> Alcohol	Place:	Year:	
<input type="checkbox"/> Drugs <input type="checkbox"/> Alcohol	Place:	Year:	
<input type="checkbox"/> Drugs <input type="checkbox"/> Alcohol	Place:	Year:	
Drug(s) of Choice:	<i>1st drug of choice</i>	<i>2nd</i>	<i>3rd</i>
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 psychiatric mental health inpatient/outpatient treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No		Currently in mental health Treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
List past or current inpatient/outpatient treatment for mental health issues:			
Place:		Year:	
Place:		Year:	
Place:		Year:	
Place:		Year:	
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: <i>(e.g., Methodone, Vivtral, Suboxone)</i>	
Medical Insurance: <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> None <input type="checkbox"/> Private Insurance (specify) <input type="checkbox"/> Other (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);	
<input type="checkbox"/> Any grade up to 11 th <input type="checkbox"/> GED <input type="checkbox"/> High School Diploma <input type="checkbox"/> Some Trade School <input type="checkbox"/> Trade School Graduate <input type="checkbox"/> Some College <input type="checkbox"/> College Graduate (2 year) <input type="checkbox"/> College Graduate (4 year) <input type="checkbox"/> Some Post Graduate <input type="checkbox"/> Advanced Degree	
Employment Status (select one):	
<input type="checkbox"/> Unemployed <input type="checkbox"/> Employed Full-time (35 or more hours/week* <input type="checkbox"/> Volunteer <input type="checkbox"/> Disabled <input type="checkbox"/> Retired <input type="checkbox"/> Employed Part-time (less than 35 hours/week)* <input type="checkbox"/> Student Full-time *Specify occupation:	
Primary Source of Support/Income (select all that apply):	
<input type="checkbox"/> Adoption Subsidy <input type="checkbox"/> Social Security (SSI) <input type="checkbox"/> Social Security Disability (SSD) <input type="checkbox"/> Welfare <input type="checkbox"/> None <input type="checkbox"/> Foster Care Subsidy <input type="checkbox"/> Retirement Plan <input type="checkbox"/> Workers' Compensation <input type="checkbox"/> Family <input type="checkbox"/> Other <input type="checkbox"/> Unemployment <input type="checkbox"/> Veteran's Benefits <input type="checkbox"/> Salary/Wages <input type="checkbox"/> Disability	
Housing Status (select one): <input type="checkbox"/> Independent <input type="checkbox"/> Dependent (Incarcerated, with friends, etc.) <input type="checkbox"/> Homeless	

FAMILY/CHILDREN INFORMATION	
Living Arrangements: <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Married* <input type="checkbox"/> Divorced <input type="checkbox"/> Living Together*	*Name of spouse or partner:
# of Children:	# of Dependent Children: Custody of all minor children: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
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: (if applicable) \$ per month
Currently have contract with your primary family? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	

MILITARY HISTORY	
Have you (defendant) ever been in the military? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please answer the questions below.</i>	
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 (includes medical) <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 criminal 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 the number of deployments to combat zones:
Conflict Era of Service (select all that apply): <input type="checkbox"/> Korea <input type="checkbox"/> ODS (Iraq/Kuwait 1990-2003) <input type="checkbox"/> OIF (Iraq 2003-2010) <input type="checkbox"/> Vietnam <input type="checkbox"/> OEF (Afghanistan 2001-present) <input type="checkbox"/> 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 COORDINATOR USE ONLY		
<i>Date(s) Distributed for Review</i>		
DA:	TX/VJO:	R/N: