



## Luzerne County Treatment Court Referral and Application Form

\*\*\*INITIAL SCREENING FORM MUST BE ATTACHED\*\*\*

**DATE OF APPLICATION/REFERRAL:**

\_\_\_\_\_

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

**OTN:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Criminal Case #:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**REFERRAL SOURCE:**

**Name:** \_\_\_\_\_ **Relationship to applicant:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

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**DEFENDANT:** \_\_\_\_\_ **Alias**(or maiden name): \_\_\_\_\_  
                    First                      Middle                      Last

Incarcerated in Luzerne County Correctional Facility

**Home Address:** \_\_\_\_\_ **County:** \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_

**EMAIL Address:** \_\_\_\_\_

Cell / Pager (\_\_\_\_) \_\_\_\_\_

**Race** (circle number)    1. Pacific Islander    2. Bi-racial    3. Black    4. Native    5. Unknown/Unreported    6. White

**Ethnicity:**            1 Hispanic            2. Non-hispanic            3. Unknown/Unreported

**Gender:** (circle one):    M    F

**Date of Birth:** \_\_\_\_\_

**Social Security Number:** \_\_\_\_\_

**Have driver's license?**    YES    NO    **Status of driver's licence:**    1.Expired    2. Not Valid    3. Valid

**Ready to regain driver's license (if revoked/suspended)?**    YES    NO

**Have you ever received prior Drug & Alcohol Inpatient and/or Outpatient Treatment?**    YES    NO

**Drugs of choice:** 1<sup>st</sup> \_\_\_\_\_ 2<sup>nd</sup> \_\_\_\_\_ 3<sup>rd</sup> \_\_\_\_\_

**Age began drug use:** \_\_\_\_\_

**Age began alcohol use:** \_\_\_\_\_

**Have you ever received Psychiatric Mental Health Inpatient and/or Outpatient Treatment Services?** YES NO

**Pharmacological Interventions for Substance Abuse?** (ex. Methadone, Vivitrol, Suboxone) \_\_\_\_\_

**If female, are you pregnant?** YES NO

**Medical insurance:** 1. Medicaid 2. Medicare 3. None 4. Private Insurance (list provider): \_\_\_\_\_

5. Other (specify): \_\_\_\_\_

**List medical conditions:** \_\_\_\_\_

**List any prescribed medications you are taking:** \_\_\_\_\_

**Highest level of education completed (circle one):** Any grade up to 11<sup>th</sup>; GED; High School Diploma; Some Trade School;  
Trade School Graduate; Some College; College Graduate 2 yr program; College Graduate 4 yr program;  
Some Post Grad Advanced Degree

**Employment Status (circle one):** Unemployed; Employed less than 35 hours/week; Employed 35 or more hours/week; Retired;  
Student-Full Time; Volunteer; Disabled

**Primary Source of Support (circle one):** Adoption Subsidy; Disability; Family; Foster Care Subsidy; Retirement Plan;  
Salary/Wages; Social Security; SSD; Unemployment; Vet Benefits; Welfare; Workers Comp.; Other

**Housing Status:** 1. Dependent (ex. living with friends or relatives, institutionalized, incarcerated, etc.)  
(circle number) 2. Independent (ex. own home, paying mortgage or rent, etc.)  
3. Homeless (ex. incarcerated with no outside residence; shelter, car, moving around between friends or relatives, etc.)

**Your current family structure:**

Number of children: \_\_\_\_\_ Number of dependent children: \_\_\_\_\_

Do you currently have custody of all of your minor children? YES NO N/A

Do you currently have visitation rights for all of your minor children who do not reside with you? YES NO N/A

Do you currently have contact with your primary family? YES NO

Have you ever been in the Military, US National Guard or Reserves? YES NO

Branch of Service: \_\_\_\_\_

Enlistment or Commissioning Date: \_\_\_\_\_

Military Discharge Date: \_\_\_\_\_

Years of Service (total): \_\_\_\_\_

Military Discharge Reason: \_\_\_\_\_

Military Rank: \_\_\_\_\_

Additional Relevant Information from DD214 or other source: YES NO comments: \_\_\_\_\_

Any criminal convictions prior to military service: YES NO highest offense grading: \_\_\_\_\_

Any convictions during military service: YES NO details: \_\_\_\_\_

Military Incarceration: YES NO

Deployed Abroad: YES NO total months: \_\_\_\_\_ locations: \_\_\_\_\_

Have you been exposed to military combat? YES NO # of deployments to a combat zone: \_\_\_\_\_  
Conflict eras of service: \_\_\_\_\_

PTSD (Post Traumatic Stress Disorder): YES NO details: \_\_\_\_\_

TBI (Traumatic Brain Injury): YES NO details: \_\_\_\_\_

MST (Military Sexual Trauma): YES NO details (optional): \_\_\_\_\_

Date referral sent to VA/VJO \_\_\_\_\_ Date assessment received from VA/VJO \_\_\_\_\_

Veteran Eligible for VA Benefits YES NO

Have you ever received services at any V.A. Hospital? YES NO

Are you currently receiving any services from a V.A. Hospital? YES NO

If yes, then where, and what type (medical, mental health, drug/alcohol, other): \_\_\_\_\_

Where did you serve if other than being deployed abroad? \_\_\_\_\_

Attorney's name: \_\_\_\_\_ phone: \_\_\_\_\_

Office Address: \_\_\_\_\_

Public  
Defender

PD App.  
Pending

Private  
Attorney

Please list alternate names and phone numbers of people who can contact you for us if we miss you at home:

_____ Name	_____ Phone number	_____ Relationship
_____ Name	_____ Phone Number	_____ Relationship

### **INSTRUCTIONS**

Send your Application Packet including the following 3 completed forms:

- Referral and Application Form
- Initial Screening Form
- \*Officer and Victim Input form- if possible. **\*Inclusion of this form will expedite application processing.**

To: **Danielle T. Goldowski, Treatment Court Coordinator**  
**Luzerne County Court Administration**  
**Penn Place Suite 314**  
**20 N. Pennsylvania Ave.**  
**Wilkes-Barre, PA 18701**  
**Phone: (570) 408-8180**  
**Fax: (570)408-8164**  
**e-mail: [danielle.goldowski@luzernecounty.org](mailto:danielle.goldowski@luzernecounty.org)**

You may submit your Application Packet by mail, email, or fax.