OFFICE OF THE WARREN COUNTY DISTRICT ATTORNEY
WARREN COUNTY COURT HOUSE
WARREN, PENNSYLVANIA 16365
Phone: 814-728-3460 FAX: 814-728-3483

TREATMENT COURT APPLICATION

Treatment Court is a post plea program. The Treatment Court Team will screen and assess applicants who are charged with crimes that are drug/alcohol addiction driven.

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

If you are charged with or have ever been convicted of any "crime of violence" as enumerated in 42 Pa.C.S.A. § 9714 (g) you are excluded from consideration for treatment court.

The District Attorney's Office by law cannot give any advice to any person seeking admission to Treatment 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 Treatment Court polices and procedures handbook prior to submitting your application.

With best regards, I am

Very truly yours,

Rob Greene, Esq.
Warren County District Attorney

IT IS A CRIME TO GIVE FALSE INFORMATION ON THIS APPLICATION.

You are advised that any false statement given to any question made with intent to mislead the District Attorney's Office or the Court is a misdemeanor of the second degree punishable by a fine not to exceed $5,000.00 and/or imprisonment not to exceed two (2) years.

Warren County Drug Treatment Court Referral and Application

APPROVED ☐ / DENIED ☐

Complete and submit this application along with a copy of the criminal complaint (if available) by mail or email to: Warren County District Attorney's Office, 204 Fourth Avenue, Warren, PA 16365 OR e-mail to BOTH: tolson@warren-county.net AND anobles@warren-county.net

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

DEFENDANT INFORMATION			
NAME: *First Middle Last*			Alias: *(or maiden name)*
Physical Address: *Street*	*City*	*State*	*Zip Code*
Mailing Address: *Same as above ☐ Street/PO Box*	*City*	*State*	*Zip Code*
County of Residence:	Currently Incarcerated: ☐ Yes ☐ No		
Home Phone: ( )	Cell: ( )	Email:	
Work Phone: ( )	Primary language spoken: ☐English ☐Spanish ☐Other:		
Date of Birth:	Social Security Number:		
Race: ☐White ☐Asian/Pacific Islander ☐Bi-racial ☐Black ☐Native ☐Unknown/Unreported			
Ethnicity: ☐Hispanic ☐Non-Hispanic ☐Unknown/Unreported	Gender: ☐Male ☐Female ☐Other		
Height:	Weight:	Hair Color:	Do you have reliable transportation: ☐Yes ☐No
Possess a driver's license? ☐Yes ☐No	Status: ☐Valid ☐Suspended ☐Expired	License #:	
If revoked/suspended, are you ready to regain driver's license? ☐Yes ☐No			
Prior participation in a problem-solving court? ☐Yes ☐No	If yes, specify county/state:		

LEGAL REPRESENTATION			
Select One: ☐Public Defender ☐ Private Attorney ☐Public Defender Pending			
Attorney's Name:	Firm(if private):		
Address: *Street*	*City*	*State*	*Zip Code*
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? ☐Yes ☐No		If yes, list:	
Attach an additional page if you have more cases and/or Charges. Additional pages attached? ☐Yes ☐No			

SUBSTANCE ABUSE HISTORY			
Have you ever abused drugs or alcohol? ☐Yes ☐No		Currently abusing? ☐Yes ☐No	
Have you ever received drug or alcohol inpatient or outpatient treatment? ☐Yes ☐No			Currently in Treatment? ☐Yes ☐No
List past or current inpatient/outpatient treatment for drugs or alcohol:			
☐Drugs ☐Alcohol Place:			Year:
☐Drugs ☐Alcohol Place:			Year:
☐Drugs ☐Alcohol Place:			Year:
☐Drugs ☐Alcohol Place:			Year:
Drug(s) of Choice:	*1st drug of choice*	*2nd*	*3rd*
Age began using drugs:	Age began alcohol use:		History of IV Drug Use? ☐Yes ☐No

MEDICAL/TREATMENT HISTORY		
Prior psychiatric mental health inpatient/outpatient treatment? ☐Yes ☐No		Currently in mental health Treatment? ☐Yes ☐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? ☐Yes ☐No		
Pharmacological Interventions (medications) for substance abuse? ☐Yes ☐No	If yes, list medications: *(e.g., Methodone, Vivtrol, Suboxone)*	
Medical Insurance: ☐Medicaid ☐Medicare ☐None ☐Private Insurance (specify) ☐Other (specify)		
If female, are you pregnant? ☐Yes ☐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 ☐College Graduate (2 year) ☐College Graduate (4 year)
☐Some Post Graduate ☐Advanced Degree

Employment Status (select one):

☐Unemployed ☐Employed Full-time (35 or more hours/week* ☐Volunteer ☐Disabled
☐Retired ☐Employed Part-time (less than 35 hours/week)* ☐Student Full-time
*Specify occupation:

Primary Source of Support/Income (select all that apply):

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

Housing Status (select one): ☐Independent ☐Dependent (Incarcerated, with friends, etc.) ☐Homeless

FAMILY/CHILDREN INFORMATION

Living Arrangements: ☐Single ☐Separated ☐Widowed ☐Married* ☐Divorced ☐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: *(if applicable)*
$ per month

Currently have contract with your primary family? ☐Yes ☐No ☐N/A

MILITARY HISTORY

Have you (defendant) ever been 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 criminal convictions prior to military service? ☐Yes ☐No

Incarcerated while in military? ☐Yes ☐No

Deployed abroad: ☐Yes ☐No

If yes,, specify where:

Military combat: ☐Yes ☐No

If yes, specify the number of deployments to combat zones:

Conflict Era of Service (select all that apply): ☐Korea ☐ODS *(Iraq/Kuwait 1990-2003)* ☐OIF *(Iraq 2003-2010)*
☐Vietnam ☐OEF(*Afghanistan 2001-present)* ☐OND*(Iraq 2010-present)*

Diagnosed with (select all that apply): ☐PTSD ☐TBI ☐MST

Eligible for VA Benefits: ☐Yes ☐No

List in detail in your own words why you want to be accepted into Treatment Court and why you think you will be successful; use a separate sheet if necessary.

I swear or affirm that the statements made in this application are true and correct to the best of my knowledge, information and belief. I understand that false statements made herein are subject to the penalties of 18 Pa. C.S.A. 4904 relating to unsworn falsification to authorities.

Date: _____ _____

(Signature of Defendant)

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Date(s) Distributed for Review		
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