VETERANS TREATMENT COURT CHECKLIST:

1. **Application:** Submit the original of the first two documents (copies attached and available on VTC website) a copy of the DD-214, and a written summary of their service to the Assistant District Attorney, Mike Shirley (mike.shirley@mctx.org), and Veterans Treatment Court Coordinator, Yolanda Alatorre (yolanda.alatorre@mctx.org).
    - □ Application
    - □ VA Form for Authorization to Release Information (must be submitted with the Application)
    - □ If no longer on active duty, DD-214 must be submitted with the application.
    - □ Written summary of military service.
2. **Preliminary DA Approval:** The DA's office will preliminarily approve the Veteran if he/she qualifies and notify the Veteran/Veteran's attorney.
3. **Preliminary Medical Approval:** After preliminary approval is received from the DA, the Veteran is to obtain a medical qualification:
    - □ Candace Witt, LCSW, VJO Specialist (Candace.Witt@va.gov) will facilitate the medical interview and forward the report to the DA.
4. **Documents Required for Final Approval:** After the Veteran medically qualifies, the Veteran's attorney will submit to the DA or the VTC Court Administrator the following completed forms with signatures/initials as indicated:
    - □ Motion and Agreement for entry into VTC
    - □ Choose: (1) for District Court case, Request for Order of Transfer/Reassignment; or (2) for County Court at Law case, Proposed Order Authorizing Participation in the Montgomery County VTC
    - □ Voluntary Consent to Disclose Participant Information
    - □ Participant Consent for Disclosure of Controlled Substance Abuse Information
    - □ Veterans Treatment Court Waiver
    - □ Montgomery County Veterans Treatment Court Program Participant Contract
5. **PR/Surety Bond:** Veteran participant may be offered a PR Bond replacing Surety Bond, or if PR Bond in place, Ancillary Conditions of Bond, as necessary, on first VTC Court appearance.
6. **Court Approval:** The original forms will be presented to the VTC at the next Court session or staffing, which is generally held on the 2nd and 4th Wednesdays of each month. (3:30 p.m. for staffing hour and 5:00 p.m. for Court), for the VTC team and Judge's review, final approval and signatures.

ONLY AFTER ALL DOCUMENTS HAVE BEEN SIGNED/INITIALED BY ALL PARTIES AND THE JUDGE, WILL THE VETERAN BE CONSIDERED "ADMITTED" INTO VETERANS TREATMENT COURT.

MONTGOMERY COUNTY VETERANS TREATMENT COURT
INITIAL APPLICATION

Please fill out this application completely. Applicants must additionally complete a VA 10-5345 form.

APPLICANT'S PERSONAL INFORMATION

NAME:

DATE OF BIRTH:	SSN:	PHONE:

CURRENT STREET ADDRESS:

CITY:	STATE:	ZIP CODE:

E-MAIL:	DEFENSE ATTORNEY:

APPLICANT'S EMPLOYMENT INFORMATION

CURRENT EMPLOYER:

LOCATION OF EMPLOYER(CITY AND STATE):	ANNUAL INCOME:
POSITION:	LENGTH OF EMPLOYMENT:

APPLICANT'S PENDING CRIMINAL CHARGE

CRIMINAL CHARGE:	CRIMINAL CHARGE:
CRIMINAL CHARGE:	CRIMINAL CHARGE:
CRIMINAL CHARGE:	CRIMINAL CHARGE:

APPLICANT'S CRIMINAL HISTORY

PRIOR FELONY CONVICTIONS:

PRIOR MISDEMEANOR CONVICTIONS:

APPLICANT'S MILITARY BACKGROUND

BRANCH:	RANK:	GRADE:	ACTIVE ☐ RESERVE ☐ GUARD ☐
START DATE:	END DATE:	DISCHARGE TYPE:	

COMBAT/ HAZARDOUS DUTY DEPLOYMENT(S):

MILITARY OCCUPATIONAL SPECIALTY (MOS):

APPLICANT'S MILITARY SERVICE RELATED DISABILITY BACKGROUND

LIST MILITARY SERVICE CONNECTED DISABILITIES:

LIST REHABILITATION OR OTHER RECOVERY PROGRAMS:

VETERAN'S ADMINISTRATION (VA) DISABILITY RATING:

Please return forms to:

Yolanda Alatorre, VTC Court Coordinator
Yolanda.alatorre@mctx.org
936-538-8195

LEGAL WRITING

I authorize the Montgomery County Veterans Treatment staff to verify the information provided on this form, including my military, criminal and employment history. I understand I will need to fill out a VA 10-5345 form in addition to this application to complete my initial application. I further understand that other forms may be presented to me or my attorney and that these forms must be completed in order for me to participate in Veterans Treatment Court. I HEREBY SWEAR AND AFFIRM that I am currently an active duty member of the United States military m: that I received an honorable discharge or general discharge from United States military service. I further HEREBY SWEAR AND AFFIRM that my military background, Social Security Number and other information I have added to this form is valid and correct. I understand that making a false statement on this form is a violation of the laws of the State of Texas that may be prosecuted as a separate criminal offense.

SIGNATURE OF APPLICANT:	DATE:

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

PRIVACY ACT AND PAPER WORK REDUCTION ACT INFORMATION: The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Act. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless is displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 2 minutes. This includes the time it will take to read the instructions, gather the necessary facts and fill out this form. The execution of this form does not authorize the release of information other than that specifically described below.

The information requested on this form is solicited under Title 38 U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164; 5 U.S.C. 552a; and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if the information including the last four of your Social Security Number (SSN) and Date of Birth (used to locate records for release) is not furnished completely and accurately, VA will be unable to comply with the request. The Veterans Health Administration may not condition treatment, payment, enrollment or eligibility on signing the authorization. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act system of records notices identified as 24VA10P2 "Patient Medical Record – VA", 08VA05 "Employee Medical File System Records (Title 38)-VA" and in accordance with the Notice of Privacy Practices. VA may also use this information to identify veterans and person claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

TO: DEPARTMENT OF VETERANS AFFAIRS *(Name and Address of VA Health Care Facility)*
Michael E. DeBakey VAMC 2002 Holcombe Blvd. Houston, TX 77030 and any other VHA hospital system where the Veteran has or will receive services.

LAST NAME- FIRST NAME- MIDDLE INITIAL	LAST 4 SSN	DATE OF BIRTH

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL, OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED
Montgomery County Veterans Court (207 W. Phillips Street, 3rd floor; Conroe, Texas 77301), all affiliated individuals, agencies, attorneys, and staff. Veteran agrees to additional guests of the court/research investigators _____Yes or _____No.

PURPOSE(S) OR NEED: Information is to be used by the individual for:

☒ TREATMENT ☐ BENEFITS ☒ LEGAL ☐ EMPLOYMENT ☐ OTHER *(Please specify)* ______

INFORMATION REQUESTED: Check applicable box(es) and state the extent or nature of information to be provided:

☐ HEALTH SUMMARY *(Prior 2 Years)*

☐ INPATIENT DISCHARGE SUMMARY *(Dates)*: ______

☐ PROGRESS NOTES:

- ☐ SPECIFIC CLINICS *(Name & Date Range)*: ______
- ☐ SPECIFIC PROVIDERS *(Name & Date Range)*: Drs. Nadaban or Stolar
- ☐ DATE RANGE: ______

☐ OPERATIVE/CLINICAL PROCEDURES *(Name & Date)*: ______

☐ LAB RESULTS:

- ☐ SPECIFIC TESTS *(Name & Date)*: ______
- ☐ DATE RANGE: ______

☐ RADIOLOGY REPORTS *(Name & Date)*: ______

☒ LIST OF ACTIVE MEDICATIONS: ______

☐ FLU VACCINATION *(Dose, Lot Number, Date & Location)*: ______

☒ OTHER *(Describe)*: Summary of MD evaluation;all relevant medical record information needed

LAST NAME- FIRST NAME- MIDDLE INITIAL	LAST 4 SSN	DATE OF BIRTH

SENSITIVE DIAGNOSES: REVIEW AND, IF APPROPRIATE, COMPLETE WHEN RELEASE IS FOR ANY PURPOSE OTHER THAN TREATMENT.

I request and authorize Department of Veterans Affairs to release the information pertaining to the condition(s) below for the non-treatment purpose(s) listed in this authorization.

☐ DRUG ABUSE ☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ SICKLE CELL ANEMIA

☐ HUMAN IMMUNODEFICIENCY VIRUS *(HIV)*

I understand that information on these sensitive diagnoses may be released for treatment purposes without me checking the above boxes, and will be released even if the boxes are unchecked unless I indicate by checking the box below that I do not want this information released for this specific disclosure.

☐ **I do not want sensitive diagnoses released for treatment purposes under this specific authorization. I realize this does not impact other future requests unrelated to this authorization.**

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing records. Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

I understand that the VA health care provider's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions.

EXPIRATION: Without my express revocation, the authorization will automatically expire.

☐ AFTER ONE-TIME DISCLOSURE, IF ALL NEEDS ARE SATISFIED

☐ ON ______________ *(enter a future date other than date signed by patient)*

☒ UNDER THE FOLLOWING CONDITION(S): Upon completion or discharge from Veterans Court and any associated probation which may last longer than court program.

PATIENT SIGNATURE *(Sign in ink)*	DATE *(mm/dd/yyyy)*
LEGAL REPRESENTATIVE SIGNATURE *(if applicable) (Sign in ink)*	DATE *(mm/dd/yyyy)*

PRINT NAME OF LEGAL REPRESENTATIVE	RELATIONSHIP TO PATIENT

FOR VA USE ONLY

TYPE AND EXTENT OF MATERIAL RELEASED

VJO will provide summary of progress via written, verbal, telephonic, and secured email that is required by court for monitoring of patient progress in treatment and compliance with legal conditions of the Veterans Treatment Court participation, inclusive of all medical record information both past and future. Information will include but not limited to : eligibility for VA services, summary of MD assessment for court, diagnoses (medical, mental health, and substance/alcohol), relevant labs, medical diagnoses, ongoing progress in treatment programming, developmental, social, financial, and military data as relevant to court/legal circumstances to the designated court team and additional guests as permitted by authorization. Information will be shared at regular intervals as needed by the court team to adequately assess progress of Veteran and compliance with court and probation guidelines. Medical record information is subject to review in open court docket. If found ineligible for the Montgomery County Veterans Court Program, disclosure will be limited to military history, VHA eligibility and lack of clinical support for admission to the Veterans Court from MD assessment required for the application process.

DATE RELEASED	RELEASED BY: