

# North Texas Veterans Court Program

## INITIAL SCREENING FORM

### YOU MUST SUBMIT A COPY OF YOUR DD214 WITH THIS APPLICATION

Please submit the completed application & DD214 to the Veterans Court Program Manager at [veteranscourt@co.collin.tx.us](mailto:veteranscourt@co.collin.tx.us)

- **Copy of DD214 Form Provided:** Yes  No
- **Signed (Wet signature) VA Release Pg 8 & 9:** Yes  No
- **Copy of TX DL or Veteran ID Card:** Yes  No

FULL NAME: \_\_\_\_\_ DATE: \_\_\_\_-\_\_\_\_-\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

NAME YOU WERE ARRESTED UNDER (IF DIFFERENT) \_\_\_\_\_

DOB: \_\_\_\_-\_\_\_\_-\_\_\_\_ SSN: \_\_\_\_-\_\_\_\_-\_\_\_\_ SEX: \_\_\_\_\_

OFFENSE: \_\_\_\_\_ CASE #: \_\_\_\_\_ COURT: \_\_\_\_\_

COUNTY YOU RECEIVED CHARGE: \_\_\_\_\_ ATTORNEY: \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ COUNTY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

LENGTH OF RESIDENCY: \_\_\_\_\_

HOME PHONE: (\_\_\_\_)\_\_\_\_-\_\_\_\_ CELL: (\_\_\_\_)\_\_\_\_-\_\_\_\_

NAME(S) OF WHOM YOU LIVE WITH: \_\_\_\_\_

ARE YOU A U.S. CITIZEN? \_\_\_\_\_ IF NOT, DO YOU HAVE LEGAL DOCUMENTS? \_\_\_\_\_

WHAT TYPE OF LEGAL DOCUMENTS DO YOU HAVE? \_\_\_\_\_

HOW LONG HAVE YOU LIVED IN THE UNITED STATES? \_\_\_\_\_

WHAT IS YOUR PRIMARY LANGUAGE? \_\_\_\_\_

DRIVER'S LICENSE # \_\_\_\_\_ ISSUING STATE: \_\_\_\_\_ EXPIRATION: \_\_\_\_\_

IF DRIVER'S LICENSE SUSPENDED, WHAT IS SUSPENSION DATE & LENGTH: \_\_\_\_\_

IF SUSPENDED, ARE YOU CURRENT ON SURCHARGES: YES OR NO

DO YOU **OWN** or **DRIVE** or **HAVE ACCESS TO A VEHICLE** ? \_\_\_\_\_

IF YOU DON'T HAVE ACCESS TO A VEHICLE, HOW DO YOU PLAN TO REPORT AND MAKE APPOINTMENTS? \_\_\_\_\_

# North Texas Veterans Court Program

## CRIMINAL HISTORY

HAVE YOU EVER BEEN ARRESTED, PRIOR TO THIS INCIDENT: YES OR NO

IF YES, LIST 1) DATE, 2) ARRESTING COUNTY, 3) CHARGE, & 4) CASE OUTCOME:

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## MILITARY

ARE / WERE YOU IN THE MILITARY? YES  NO  BRANCH: \_\_\_\_\_

DISCHARGE DATE: \_\_\_\_\_ TYPE OF DISCHARGE: \_\_\_\_\_

IF DISCHARGED FOR MISCONDUCT, WHAT WAS THE MISCONDUCT: \_\_\_\_\_

WERE YOU DEPLOYED: YES  NO  IF YES, WHERE: \_\_\_\_\_

DO YOU HAVE COMBAT EXPERIENCE: YES  NO

DO YOU HAVE A COMBAT-RELATED INJURY: YES  NO

IF YES, PLEASE GIVE DETAILS: \_\_\_\_\_

DEPT. OF DEFENSE MILITARY DISCHARGE FORM DD-214 FORM ATTACHED? YES  NO

## EMPLOYMENT

EMPLOYER: \_\_\_\_\_ HOW LONG: \_\_\_\_\_

DO YOU WORK: **FULL TIME** or **PART TIME** or **TEMPORARY**

WHAT DO YOU DO? \_\_\_\_\_

EMPLOYER ADDRESS: \_\_\_\_\_

PHONE: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ OK TO CONTACT YOU AT WORK? \_\_\_\_\_

MONTHLY INCOME? \_\_\_\_\_

DO YOU RECEIVE ANY OTHER INCOME? \_\_\_\_\_ WHAT KIND? \_\_\_\_\_

HOW MUCH DO YOU RECEIVE? \_\_\_\_\_ HOW OFTEN? \_\_\_\_\_

DO YOU HAVE HEALTH INSURANCE? \_\_\_\_\_

MEDICARE \_\_\_\_\_ MEDICAID \_\_\_\_\_

IF YOU RECEIVE SSI / SSDI ARE YOU THE PAYEE? \_\_\_\_\_

IF NOT WHO IS? \_\_\_\_\_

# North Texas Veterans Court Program

## EDUCATION

DID YOU GRADUATE HIGH SCHOOL? \_\_\_\_\_ YEAR OF GRADUATION: \_\_\_\_\_

HIGHEST GRADE COMPLETED: \_\_\_\_\_ DO YOU HAVE A GED? \_\_\_\_\_ YEAR: \_\_\_\_\_

HIGH SCHOOL: \_\_\_\_\_

WERE YOU ENROLLED IN ANY SPECIAL EDUCATION CLASSES? \_\_\_\_\_

COLLEGE / UNIVERSITY: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_

ARE YOU CURRENTLY IN SCHOOL? \_\_\_\_\_ NUMBER OF HOURS: \_\_\_\_\_

## DEPENDANTS

MARITAL STATUS: **SINGLE** or **MARRIED** or **DIVORCED** or **SEPARATED** or **WIDOWED**

HOW LONG: \_\_\_\_\_ SPOUSE'S NAME: \_\_\_\_\_

NUMBER OF CHILDREN: \_\_\_\_\_

DO YOU PROVIDE FINANCIAL SUPPORT FOR YOUR CHILDREN? \_\_\_\_\_

HOW MUCH DO YOU PROVIDE? \_\_\_\_\_ HOW OFTEN? \_\_\_\_\_

<b>Name of Child:</b>	<b>Live with you?</b> (Circle one)	<b>Gender</b> (Circle one)	<b>Date of Birth</b>
_____	Y / N	M / F	_____
_____	Y / N	M / F	_____
_____	Y / N	M / F	_____
_____	Y / N	M / F	_____
_____	Y / N	M / F	_____

# North Texas Veterans Court Program

## DRUG / ALCOHOL HISTORY

1. **NAME OF DRUG:** \_\_\_\_\_

HOW DID YOU TAKE IT? SMOKE or SNORT or DRINK or PILLS or SHOOT or OTHER \_\_\_\_\_

HOW OFTEN DID YOU USE IT? \_\_\_\_\_

WHAT AMOUNT DID YOU USUALLY USE? \_\_\_\_\_ \$ \_\_\_\_\_

AGE YOU FIRST USED: \_\_\_\_\_ DATE YOU LAST USED: \_\_\_\_\_

2. **NAME OF DRUG:** \_\_\_\_\_

HOW DID YOU TAKE IT? SMOKE or SNORT or DRINK or PILLS or SHOOT or OTHER \_\_\_\_\_

HOW OFTEN DID YOU USE IT? \_\_\_\_\_

WHAT AMOUNT DID YOU USUALLY USE? \_\_\_\_\_ \$ \_\_\_\_\_

AGE YOU FIRST USED: \_\_\_\_\_ DATE YOU LAST USED: \_\_\_\_\_

3. **NAME OF DRUG:** \_\_\_\_\_

HOW DID YOU TAKE IT? SMOKE or SNORT or DRINK or PILLS or SHOOT or OTHER \_\_\_\_\_

HOW OFTEN DID YOU USE IT? \_\_\_\_\_

WHAT AMOUNT DID YOU USUALLY USE? \_\_\_\_\_ \$ \_\_\_\_\_

AGE YOU FIRST USED: \_\_\_\_\_ DATE YOU LAST USED: \_\_\_\_\_

4. **NAME OF DRUG:** \_\_\_\_\_

HOW DID YOU TAKE IT? SMOKE or SNORT or DRINK or PILLS or SHOOT or OTHER \_\_\_\_\_

HOW OFTEN DID YOU USE IT? \_\_\_\_\_

WHAT AMOUNT DID YOU USUALLY USE? \_\_\_\_\_ \$ \_\_\_\_\_

AGE YOU FIRST USED: \_\_\_\_\_ DATE YOU LAST USED: \_\_\_\_\_

## MEDICAL/PSYCHIATRIC HISTORY

HAVE YOU HAD PRIOR TREATMENT FOR SUBSTANCE /ABUSE OR A MENTALL ILLNESS?

<u>Dates of Admission</u>	<u>Name of Hospital</u>	<u>City</u>	<u>State</u>	<u>Reason for Admission</u>

# North Texas Veterans Court Program

ARE YOU CURRENTLY UNDER A DOCTOR'S CARE? YES NO

CURRENT **MEDICAL** DIAGNOSIS: \_\_\_\_\_

DID YOU SUFFER A COMBAT INJURY? YES NO IF YES: WHEN, WHERE & DETAILS?

CURRENT **PSYCHIATRIC** DIAGNOSIS \_\_\_\_\_

HAS A MEDICAL PROFESSIONAL DIAGNOSED YOU SPECIFICALLY WITH PTSD? YES  NO

IF YES: WHEN \_\_\_\_\_

NAME DIAGNOSING PROFESSIONAL \_\_\_\_\_

NAME OF DOCTOR: \_\_\_\_\_ REASON FOR SEEING: \_\_\_\_\_

NAME OF DOCTOR: \_\_\_\_\_ REASON FOR SEEING: \_\_\_\_\_

NAME OF DOCTOR: \_\_\_\_\_ REASON FOR SEEING: \_\_\_\_\_

ARE YOU CURRENTLY TAKING MEDICATION(S)? \_\_\_\_\_

MEDICATION: \_\_\_\_\_ PRESCRIBING DOCTOR: \_\_\_\_\_

MEDICATION: \_\_\_\_\_ PRESCRIBING DOCTOR: \_\_\_\_\_

MEDICATION: \_\_\_\_\_ PRESCRIBING DOCTOR: \_\_\_\_\_

MEDICATION: \_\_\_\_\_ PRESCRIBING DOCTOR: \_\_\_\_\_

## **REFERENCES** (*family / friends*)

**NAME:** \_\_\_\_\_ **RELATIONSHIP TO YOU?** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**CITY:** \_\_\_\_\_ **COUNTY:** \_\_\_\_\_ **STATE:** \_\_\_\_\_ **ZIP:** \_\_\_\_\_

**PHONE:** (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ **PHONE:** (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**NAME:** \_\_\_\_\_ **RELATIONSHIP TO YOU?** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**CITY:** \_\_\_\_\_ **COUNTY:** \_\_\_\_\_ **STATE:** \_\_\_\_\_ **ZIP:** \_\_\_\_\_

**PHONE:** (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ **PHONE:** (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

# North Texas Veterans Court Program

Have you ever been accepted to and/or participated in any other Veterans Courts?  YES  NO

IF YES, WHICH COURT? Please include dates. \_\_\_\_\_

Did you successfully complete the program?  YES  NO

If NO, why were you unsuccessfully discharged? \_\_\_\_\_

## ATTORNEY INFORMATION

NAME: \_\_\_\_\_

PHONE: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ EMAIL: \_\_\_\_\_

TO OBTAIN A COPY OF YOUR DD214 FROM THE GOVERNMENT, GO TO:

[HTTP://WWW.ARCHIVES.GOV/VETERANS/MILITARY-SERVICE-RECORDS/](http://www.archives.gov/veterans/military-service-records/)

***I HEREBY ACKNOWLEDGE AND CERTIFY THAT I HAVE ANSWERED ALL QUESTIONS ABOVE AND THAT THE INFORMATION IS TRUE AND CORRECT.***

\_\_\_\_\_  
*Applicant Signature*

\_\_\_\_\_  
*Date*

**Visit Our Website:**

[www.northtexasveteranscourt.com](http://www.northtexasveteranscourt.com)



**TEXAS VETERANS  
COMMISSION**

*"Helping Veterans Starts Here"*

1-800-252-VETS(8387)  
[www.tvc.texas.gov](http://www.tvc.texas.gov)

This program is supported by a grant from the Texas Veterans Commission *Fund for Veterans' Assistance*. The *Fund for Veterans' Assistance* provides grants to organizations serving veterans and their families.

[www.tvc.state.tx.us](http://www.tvc.state.tx.us)

# North Texas Veterans Court Program

## INFORMED CONSENT FOR INTERVIEW AND PERMISSION TO RELEASE INFORMATION

The goals of the North Texas Veterans Court Program are consistent with **Texas Health and Safety Code 617.001**, to provide diversion of Justice-Involved Veterans whom combat service resulted in a brain injury, mental illness, or mental disorder, including post-traumatic stress disorder. The Veterans Court Program will identify eligible veterans and link them to needed services as an alternative to subjecting those defendants to the traditional criminal justice system. By successfully completing the program, eligible charges will be dismissed and eligible for expunction.

I, the undersigned, understand that I am being interviewed by a member of the North Texas Veterans Court Program to help determine if I preliminarily meet the clinical criteria for admission into the Veterans Court Program. I understand that this interview does not mean I am accepted into the program and as such, I am required to follow all current bonds, pretrial, or court ordered conditions.

I hereby consent to the interview as described above and give my permission for information gathered during this interview, and other sources to be shared with the members of the Veterans Court Program Team which includes but is not limited to: other mental health professionals for consultation and training purposes, mentor coordinator, criminal defense attorneys, prosecutors and other criminal justice/court staff and personnel as outlined in **Texas Health and Safety Code Sec. 611.004**. By signing this document, I understand I am waiving my legal rights to confidentiality to allow judicial efficiency due to my current pending case(s).

I agree to meet with my attorney to discuss the conditions of the program to ensure I am making an informed decision to enter the program before I sign any required legal documents. I understand that admission to this program is voluntary and that the final approval for admission will be determined by a representative of the District Attorney's Office and the Judge of the North Texas Veterans Court Program.

Applicant Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Witness: \_\_\_\_\_

Date: \_\_\_\_\_



LAST NAME- FIRST NAME- MIDDLE INITIAL ✓	LAST 4 SSN ✓	DATE OF BIRTH ✓
<b>AUTHORIZATION</b>		
<p>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.</p> <p>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.</p>		
<b>EXPIRATION</b>		
<p>Without my express revocation, the authorization will automatically expire.</p> <p><input type="checkbox"/> UPON SATISFACTION OF THE NEED FOR DISCLOSURE</p> <p><input type="checkbox"/> ON _____ (enter a future date other than date signed by patient)</p> <p><input checked="" type="checkbox"/> UNDER THE FOLLOWING CONDITION(S): <u>1. Written revocation submitted to VA staff; 2. Written verification from court that VA recs are no longer required; 3. Upon court completion</u></p>		
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	
<b>FOR VA USE ONLY</b>		
TYPE AND EXTENT OF MATERIAL RELEASED		
DATE RELEASED	RELEASED BY:	

The Alcohol Use Disorders Identification Test (AUDIT)

**1. How often do you have a drink containing alcohol?**

- (0) Never (Skip to Questions 9-10)
- (1) Monthly or less
- (2) 2 to 4 times a month
- (3) 2 to 3 times a week
- (4) 4 or more times a week

**2. How many drinks containing alcohol do you have on a typical day when you are drinking?**

- (0) 1 or 2
- (1) 3 or 4
- (2) 5 or 6
- (3) 7, 8, or 9
- (4) 10 or more

**3. How often do you have six or more drinks on one occasion?**

- (0) Never
- (1) Less than monthly
- (2) Monthly
- (3) Weekly
- (4) Daily or almost daily

**4. How often during the last year have you found that you were not able to stop drinking once you had started?**

- (0) Never
- (1) Less than monthly
- (2) Monthly
- (3) Weekly
- (4) Daily or almost daily

**5. How often during the last year have you failed to do what was normally expected from you because of drinking?**

- (0) Never
- (1) Less than monthly
- (2) Monthly
- (3) Weekly
- (4) Daily or almost daily

**6. How often during the last year have you been unable to remember what happened the night before because you had been drinking?**

- (0) Never
- (1) Less than monthly
- (2) Monthly
- (3) Weekly
- (4) Daily or almost daily

**7. How often during the last year have you needed an alcoholic drink first thing in the morning to get yourself going after a night of heavy drinking?**

- (0) Never
- (1) Less than monthly
- (2) Monthly
- (3) Weekly
- (4) Daily or almost daily

**8. How often during the last year have you had a feeling of guilt or remorse after drinking?**

- (0) Never
- (1) Less than monthly
- (2) Monthly
- (3) Weekly
- (4) Daily or almost daily

**9. Have you or someone else been injured as a result of your drinking?**

- (0) No
- (2) Yes, but not in the last year
- (4) Yes, during the last year

**10. Has a relative, friend, doctor, or another health professional expressed concern about your drinking or suggested you cut down?**

- (0) No
- (2) Yes, but not in the last year
- (4) Yes, during the last year

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

### DRUG USE QUESTIONNAIRE (DAST – 20)

The following questions concern information about your potential involvement with drugs **not including alcoholic beverages** during the past 12 months. Carefully read each statement and decide if your answer is “Yes” or “No”. Then, circle the appropriate response beside the question.

In the statements, “drug abuse” refers to (1) the use of prescribed or over the counter drugs in excess of the directions and (2) any non-medical use of drugs. The various classes of drugs may include: cannabis (e.g. marijuana, hash), solvents, tranquillizers (e.g. Valium), barbiturates, cocaine, stimulants (e.g. speed), hallucinogens (e.g. LSD) or narcotics (e.g. heroin). Remember that the questions **do not** include alcoholic beverages.

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

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## Adult Version

**These questions refer to the past 12 months.**

**Circle Your  
Response**

- |  |     |    |
|--|-----|----|
| 1. Have you used drugs other than those required for medical reasons?  | Yes | No |
| 2. Have you abused prescription drugs?   | Yes | No |
| 3. Do you abuse more than one drug at a time?  | Yes | No |
| 4. Can you get through the week without using drugs?   | Yes | No |
| 5. Are you always able to stop using drugs when you want to?   | Yes | No |
| 6. Have you had "blackouts" or "flashbacks" as a result of drug use?   | Yes | No |
| 7. Do you every feel bad or guilty about your drug use?  | Yes | No |
| 8. Does your spouse (or parents) ever complain about your involvement with drugs?  | Yes | No |
| 9. Has drug abuse created problems between you and your spouse or your parents?  | Yes | No |
| 10. Have you lost friends because of your use of drugs?  | Yes | No |
| 11. Have you neglected your family because of your use of drugs?   | Yes | No |
| 12. Have you been in trouble at work (or school) because of drug abuse?  | Yes | No |
| 13. Have you lost your job because of drug abuse?  | Yes | No |
| 14. Have you gotten into fights when under the influence of drugs?   | Yes | No |
| 15. Have you engaged in illegal activities in order to obtain drugs?   | Yes | No |
| 16. Have you been arrested for possession of illegal drugs?  | Yes | No |
| 17. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?                               | Yes | No |
| 18. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, etc.)? | Yes | No |
| 19. Have you gone to anyone for help for drug problem?   | Yes | No |
| 20. Have you been involved in a treatment program specifically related to drug use?  | Yes | No |

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