ATTORNEYS

Help your client fill this application out completely. **Only complete applications will be processed.** Email completed application to the VTC Court Coordinator, Janine Capetillo, at janine.capetillo@dallascounty.org, or call her at 214-653-5935 to drop off an application in court.

DD-214

Submit a copy of Form DD-214 (DISCHARGE PAPERWORK) with this application.

ROIs

Fill out ALL MARKED AREAS on the attached Release of Information forms (ROI's).

CONTACT INFORMATION:

Client's Name: _____

Client's Email: _____

Attorney's Email: _____

Old versions of this application are outdated and will not be accepted.

This application is current as of November 2024.

Thank you for your application to VTC!

NOTICE TO ATTORNEYS

CASES NEVER ELIGIBLE FOR VTC: SEX CASES, MAN/DEL CASES, CASES INVOLVING DEATH OF A VICTIM.

PLEASE ADVISE YOUR CLIENT OF THE FOLLOWING BEFORE APPLYING TO VETERANS TREATMENT COURT:

1.) You are not eligible for VTC if you have ever participated in a VTC in another county, and had your case dismissed or expunged as a result. You must sign an affidavit (located in application packet) swearing that you have not done such in order to be considered for participation in Dallas County VTC.
2.) Veterans Treatment Court has a statutory minimum duration of 6 months, but a participant could be in the program for as long as the legally allowable term of probation associated with his or her charge. The duration of the program within the abovementioned timeframe is determined by each participant's treatment plan and individual progress. If you do not have a mental health or substance abuse problem that requires treatment you are not eligible.
3.) This is a TREATMENT COURT. You must have a mental health and/or substance abuse problem in need of treatment in order to be eligible.
4.) Treatment may be recommended on an inpatient and/or outpatient basis.
5.) If you won't agree to participate in recommended treatment you are not eligible.
6.) All participants are subject to the requirement of a TAM, Soberlink, Interlock, drug patch or other similar monitoring device if deemed necessary by the VTC team.
7.) You will be required to come to court 1x/week, report to your supervision officer 1x/week, treatment classes/groups as recommended, and are subject to being required to appear on a random basis for UAs.

Please sign below acknowledging your understanding of the above terms and conditions as they relate to application and participation in Veterans Treatment Court before proceeding with the application.

X_____ X_____

Attorney for Applicant Veterans Treatment Court Applicant

DALLAS COUNTY VETERANS TREATMENT COURT
CODE COMPLIANCE AFFIDIAVIT

THE STATE OF TEXAS

BEFORE ME, _____

COUNTY OF DALLAS

A notary public in and for said County, State of Texas, on this day personally appeared, _____, who after being by me duly sworn, on oath, deposes and says that I am competent and qualified to make this affidavit and I have personal knowledge of the fact stated here in and such facts are true and correct:

I further declare that:

In compliance with Texas Code of Criminal Procedure Art. 55.01(a)(2)(A)(ii)(a-3) I am applying to Dallas County Veterans Treatment Court in good faith, swearing, through this affidavit, that I have never before receive an expunction as a result of completion of any Veterans Treatment Court.

I have personal knowledge of the above facts and I swear that the above statements are true and correct.

_____
AFFIANT

Subscribed and sworn to before me this the _____day of _____, 20__.

_____
NOTARY PUBLIC
DALLAS COUNTY, TEXAS

CODE OF CRIMINAL PROCEDURE

See Art. 55.01(a)(2)(A)(ii)(a-3)

Art. 55.01. RIGHT TO EXPUNCTION. **(a) A person who has been placed under a custodial or noncustodial arrest for commission of either a felony or misdemeanor is entitled to have all records and files relating to the arrest expunged if:**

(1) the person is tried for the offense for which the person was arrested and is:

(A) acquitted by the trial court, except as provided by Subsection (c); or

(B) convicted and subsequently:

(i) pardoned for a reason other than that described by Subparagraph (ii); or

(ii) pardoned or otherwise granted relief on the basis of actual innocence with respect to that offense, if the applicable pardon or court order clearly indicates on its face that the pardon or order was granted or rendered on the basis of the person's actual innocence; or

(2) the person has been released and the charge, if any, has not resulted in a final conviction and is no longer pending and there was no court-ordered community supervision under Chapter 42A for the offense, unless the offense is a Class C misdemeanor, provided that:

(A) regardless of whether any statute of limitations exists for the offense and whether any limitations period for the offense has expired, an indictment or information charging the person with the commission of a misdemeanor offense based on the person's arrest or charging the person with the commission of any felony offense arising out of the same transaction for which the person was arrested:

(i) has not been presented against the person at any time following the arrest, and:

(a) at least 180 days have elapsed from the date of arrest if the arrest for which the expunction was sought was for an offense punishable as a Class C misdemeanor and

if there was no felony charge arising out of the same transaction for which the person was arrested;

(b) at least one year has elapsed from the date of arrest if the arrest for which the expunction was sought was for an offense punishable as a Class B or A misdemeanor and if there was no felony charge arising out of the same transaction for which the person was arrested;

(c) at least three years have elapsed from the date of arrest if the arrest for which the expunction was sought was for an offense punishable as a felony or if there was a felony charge arising out of the same transaction for which the person was arrested; or

(d) the attorney representing the state certifies that the applicable arrest records and files are not needed for use in any criminal investigation or prosecution, including an investigation or prosecution of another person; or

(ii) if presented at any time following the arrest, was dismissed or quashed, and the court finds that the indictment or information was dismissed or quashed because:

(a) the person completed a veterans treatment court program created under Chapter 124, Government Code, or former law, subject to Subsection (a-3);

(b) the person completed a mental health court program created under Chapter 125, Government Code, or former law, subject to Subsection (a-4);

(c) the person completed a pretrial intervention program authorized under Section 76.011, Government Code, other than a veterans treatment court program created under Chapter 124, Government Code, or former law, or a mental health court program created under Chapter 125, Government Code, or former law;

(d) the presentment had been made because of mistake, false information, or other similar reason indicating absence of probable cause at the time of the dismissal to believe the person committed the offense; or

(e) the indictment or information was void; or

(B) prosecution of the person for the offense for which the person was arrested is no longer possible because the limitations period has expired.

(a-1) Notwithstanding any other provision of this article, a person may not expunge records and files relating to an arrest that occurs pursuant to a warrant issued under Article 42A.751(b).

(a-2) Notwithstanding any other provision of this article, a person who intentionally or knowingly absconds from the jurisdiction after being released under Chapter 17 following an arrest is not eligible under Subsection (a)(2)(A)(i)(a), (b), or (c) or Subsection (a)(2)(B) for an expunction of the records and files relating to that arrest.

(a-3) A person is eligible under Subsection (a)(2)(A)(ii)(a) for an expunction of arrest records and files only if:

(1) the person has not previously received an expunction of arrest records and files under that sub-subparagraph; and

(2) the person submits to the court an affidavit attesting to that fact.

ATTACH A COPY OF DD-214 DISCHARGE PAPERWORK TO THIS APPLICATION

****If do not have a DD-214 because you are on active duty now please check here _____.**

Form Approved: OMB No. 2900-0028
Respondent Burden: 7.5 minutes

Department of Veterans Affairs

REQUEST FOR AND CONSENT TO RELEASE OF INFORMATION FROM INDIVIDUAL'S RECORDS

PRIVACY ACT STATEMENT: 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, United States Code, and will authorize release of the information you specify. The information may also be disclosed outside VA as permitted by law to include disclosure as stated in the "Notices of Systems of VA Records" published in the Federal Register in accordance with the Privacy Act of 1974.

RESPONDENT BURDEN: VA may not conduct or sponsor, and the respondent is not required to respond, to this collection of information unless it displays a valid OMB Control Number. The Privacy Act of 1974 (5 U.S.C. 552a) and VA's confidentiality statute (38 U.S.C. 5701) as implemented by 38 CFR 1.526(a) and 38 CFR 1.576(b) require individuals to provide written consent before documents or information can be disclosed to third parties not allowed to receive records or information under any other provision of law. The information requested is approved under OMB Control Number 2900-0028 and is necessary to ensure that the statutory requirements of the Privacy Act and VA's confidentiality statute are met.

Responding to this collection of information is voluntary. However, if the information is not furnished, we may not be able to comply with your request. Public reporting burden for this collection is estimated to average 7.5 minutes per respondent, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspects of this collection of Information, including suggestions for reducing this burden, to the VA Clearance Officer (005E3), 810 Vermont Avenue, NW, Washington, DC 20420. **Send comments only. Do not send** this form or requests for benefits to this address.

TO	Department of Veterans Affairs VA Waco Regional Office (349) 701 Clay Ave. Waco, Texas 76799	NAME OF INDIVIDUAL *(Type or print)*	
		VA FILE NO. *(Include prefix)*	SOCIAL SECURITY NUMBER

NAME AND ADDRESS OF ORGANIZATION OR INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

Dallas Co. VTC, 133 N. Riverfront Blvd., Dallas, TX 75207. VHA; VBA; Correctional Staff; Community Supervision Officers; Jail/Court Mental Health Diversion Staff; Veterans Treatment Court to include: Judge, Staff, Team, Guests, and all Officers of the Court.

INITIAL HERE _____

VETERAN'S REQUEST

I hereby request and authorize the Department of Veterans Affairs to release the following information from the records identified above to the organization, agency, or individual named hereon: ▶	NAME

INFORMATION REQUESTED *(Number each item requested and give the dates or approximate dates - period from and to - covered by each.)*

VBA will provide summary of progress via written, verbal, telephonic, fax, and/or secured email that is required by the court for monitoring of Veteran benefits/claims progress and compliance. Data will be inclusive of relevant benefit information, but not to be limited to: Veteran eligibility verification, DD214, service connected compensation, military service, CAPRI, social security benefit information, and any other Veteran benefit related information relevant to court/legal circumstances. Information will be shared at regular intervals, as needed by the court team to adequately assess Veteran progress and compliance with Veterans Treatment Court guidelines. Veteran Benefits record information is subject to review in open court.

INITIAL HERE _____

PURPOSE(S) FOR WHICH THE INFORMATION IS TO BE USED.

To ensure the Veteran meets the required eligibility criteria and to assist with adhering to the Veterans Treatment Court guidelines.

NOTE: *Additional information may be listed on the reverse side of this form.*

SIGNATURE OF INDIVIDUAL OR PERSON AUTHORIZED TO SIGN FOR INDIVIDUAL *(Attach authority to sign, e.g., POA)*	DATE

DALLAS COUNTY VETERANS TREATMENT COURT APPLICATION

The Dallas County Veterans Treatment Court ("VTC") is a diversion or pre-adjudication treatment program for veterans, reservists or active duty service men and women that are charged with an offense in Dallas County. If an eligible Veteran participates and graduates from VTC, his/her case will be dismissed and expunged at no cost to the Veteran.

REQUIREMENTS FOR PARTICIPATION:

- Combat service is no longer a requirement for participation, and Veterans with other than Honorable discharges will be evaluated on a case by case basis.
- Current offense(s) must be one where a prosecutor would normally consider a community supervision recommendation.
- Per statute, upon evaluation a mental health assessor must find:
  A. A mental disease or defect (i.e. mental health or substance abuse issue)
  B. That the mental disease or defect contributed, in whole or in part, to the charged offense
- The Veteran must be willing to follow the treatment plan prescribed by the VTC team in order to address the mental health and/or substance abuse issue(s) that led to the criminal charge.
- The Veteran grants VTC permission to have access to the Veteran's treatment records and, as necessary, to the Veteran's military records in order to provide appropriate treatment.
- Both felony and misdemeanor cases will be considered, including, but not limited to, felony and misdemeanor DWIs and Aggravated cases.
- No MAN/DEL CS, kidnapping, sex cases, or cases involving a death will be considered.

TO APPLY:

Please email a completed application and DD-214 to **janine.capetillo@dallascounty.org**. **ONLY FULLY COMPLETED APPLICATIONS WILL BE CONSIDERED.**

THE PROCESS:

Once a completed application is received it will be forwarded to the VTC ADA who will either approve or deny the application for ATRS evaluation. If the case is denied by the District Attorney's Office, the attorney will be notified by email, and none of the information gathered during the application process will be used against the Veteran in the further prosecution of his/her case. If the District Attorney's Office approves the application for ATRS evaluation, the VTC ATRS clinician will contact the Veteran to schedule an evaluation. Once all of the Veteran's records are received from the VA, and the ATRS is complete, the case will be staffed by the VTC team. The attorney will be notified of the determination via email.

ATTORNEY INFORMATION

NAME: _____ CELL: (_____) _____-_____

E-MAIL: _____

CASE INFORMATION

IS THE VETERAN CURRENTLY IN JAIL? YES ☐ or NO ☐

LIST ALL CASES TO BE CONSIDERED FOR THE VETERANS TREATMENT COURT:

****Cases not listed below will NOT be considered for VTC****

Case #: _____ **Charge:** _____ **Court:** _____

Case #: _____ **Charge:** _____ **Court:** _____

Case #: _____ **Charge:** _____ **Court:** _____

Case #: _____ **Charge:** _____ **Court:** _____

Case #: _____ **Charge:** _____ **Court:** _____

WAS THE VETERAN ARRESTED FOR ANY CLASS C OR OTHER UNLISTED/UNFILED CHARGES OUT OF THE SAME TRANSACTION AS ANY OF THE CASE(S) LISTED ABOVE? YES or NO

IF YES, LIST HERE: _____

_____

VETERAN APPLICANT INFORMATION

FULL NAME: _____ DOB: _______________

NAME YOU WERE ARRESTED UNDER IF DIFFERENT FROM ABOVE:

_____ IF NOT: ☐ N/A

HOME PHONE: (_____) _____-_____ CELL: (_____) _____-_____

E-MAIL: _____

SSN: _____-_____-_____ RACE: _____ ETHINICITY_____ SEX: _____

CURRENT ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

COUNTY: _____ LENGTH OF RESIDENCY: _____

NAME(S) OF INDIVIDUAL(S) WITH WHOM YOU LIVE: **RELATIONSHIP TO YOU:**

_____ _____

_____ _____

_____ _____

_____ _____

ALTERNATE CONTACT (SOMEONE WE CAN CALL IF WE CANNOT REACH YOU):

NAME: _____ CELL: (_____) _____-_____

RELATIONSHIP TO YOU: _____

E-MAIL: _____

ALTERNATE CONTACT (SOMEONE WE CAN CALL IF WE CANNOT REACH YOU):

NAME: _____ CELL: (_____) _____-_____

RELATIONSHIP TO YOU: _____

E-MAIL: _____

CITIZENSHIP

ARE YOU A U.S. CITIZEN? YES ☐ or NO ☐

IF NOT, DO YOU HAVE LEGAL DOCUMENTS? YES ☐ or NO ☐

PLACE OF BIRTH: _____ PRIMARY LANGUAGE: _____

DRIVERS LICENSE & VEHICLE

DRIVERS LICENSE #_____ ISSUING STATE _____ EXPIRATION _____

IS YOUR LICENSE SUSPENDED? YES or NO

DO YOU HAVE AN OCCUPATIONAL DRIVERS LICENSE? YES ☐ or NO ☐

DO YOU CURRENTLY HAVE AN INTERLOCK DEVICE ON YOUR VEHICLE? YES ☐ or NO ☐

DO YOU: ☐ OWN A VEHICLE ☐ DRIVE A WORK VEHICLE

☐ HAVE ACCESS TO A VEHICLE ☐ USE PUBLIC TRANSPORTATION

ALL VEHICLES ACCESSIBLE TO YOU MUST BE LISTED BELOW:

PRIMARY VEHICLE:

MAKE: _____ MODEL: _____ COLOR: _____ YEAR: _____

SECONDARY VEHICLE: IF NONE: ❑ N/A

MAKE: _____ MODEL: _____ COLOR: _____ YEAR: _____

TO WHOM DOES THE SECONDARY VEHICLE BELONG?

NAME: _____ CELL: (_____) _____-_____

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

EMPLOYMENT:

☐ FULL TIME ☐ PART-TIME ☐ TEMPORARY ☐ SEASONAL

EMPLOYER: _____

NAME: _____ CELL: (_____) _____-_____

HOW LONG: _____EMPLOYMENT START DATE: _______________

TYPE OF WORK: _____

SCHEDULE_____

TOTAL MONTHLY INCOME: $_____ HOURLY PAY: $_____

SOURCE(S) OF INCOME (CHECK ALL THAT APPLY): ☐ EMPLOYMENT ☐ UNEMPLOYMENT

☐ GI BILL ☐ SSI/SSDI ☐ RETIREMENT ☐ VA DISABILITY ☐ VA PENSION ☐ OTHER

HEALTH INSURANCE: ☐ PRIVATE ☐ MEDICARE ☐ MEDICAID ☐ NONE

MILITARY

YEARS OF SERVICE: _____ to _____ BRANCH: _____

MOS: _____ STATIONED: _____

DISCHARGE RANK: _____ DISCHARGE DATE: _______________

DISCHARGE TYPE: _____

COMBAT EXPOSURE? YES☐ or NO☐

HOSTILE FIRE OR IMMINENT DANGER PAY? YES☐ or NO☐

LIST ANY DEPLOYMENTS:

DATE: _______________ LOCATION: _____

DATE: _______________ LOCATION: _____

DATE: _______________ LOCATION: _____

WHAT (IF ANY) CAMPAIGN MEDALS DID YOU RECEIVE:

_____

EDUCATION

HIGHEST GRADE COMPLETED: _____ YEAR GRADUATED: _____

EARNED A GED? YES☐ or NO☐ YEAR PASSED GED: _____

NAME OF HIGH SCHOOL / STATE:

_____

CURRENTLY ENROLLED SCHOOL:

_____

NAME OF COLLEGE / UNIVERSITY / TRADE SCHOOL:

_____

☐ FULL TIME STUDENT ☐ PART-TIME STUDENT ☐ ONSITE ☐ VIRTUAL

DEPENDANTS

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED

HOW LONG: _______________ SPOUSE'S NAME: ____

NUMBER OF CHILDREN: ________________________

DO YOU PROVIDE FINANCIAL SUPPORT FOR YOUR CHILDREN? YES☐ or NO☐

AMOUNT: $_________________________ FREQUENCY: ___________________________________

NAME OF CHILD: ____

LIVE WITH YOU? YES☐ or NO☐ GENDER: M☐ or F☐ DOB: ______________________

NAME OF CHILD: ____

LIVE WITH YOU? YES☐ or NO☐ GENDER: M☐ or F☐ DOB: ______________________

NAME OF CHILD: ____

LIVE WITH YOU? YES☐ or NO☐ GENDER: M☐ or F☐ DOB: ______________________

NAME OF CHILD: ____

LIVE WITH YOU? YES☐ or NO☐ GENDER: M☐ or F☐ DOB: ______________________

NAME OF CHILD: ____

LIVE WITH YOU? YES☐ or NO☐ GENDER: M☐ or F☐ DOB: ______________________

NAME OF CHILD: ____

LIVE WITH YOU? YES☐ or NO☐ GENDER: M☐ or F☐ DOB: ______________________

NAME OF CHILD: ____

LIVE WITH YOU? YES☐ or NO☐ GENDER: M☐ or F☐ DOB: ______________________

DRUG / ALCOHOL HISTORY

1. NAME OF DRUG: _____

   HOW DID YOU TAKE IT? ☐ SMOKE ☐ SNORT ☐ DRINK ☐ PILLS ☐ SHOOT

   ☐ 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 ☐ SNORT ☐ DRINK ☐ PILLS ☐ SHOOT

   ☐ 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 ☐ SNORT ☐ DRINK ☐ PILLS ☐ SHOOT

   ☐ 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 ☐ SNORT ☐ DRINK ☐ PILLS ☐ SHOOT

   ☐ OTHER: _____

   HOW OFTEN DID YOU USE IT? _____

   WHAT AMOUNT DID YOU USUALLY USE? _____

   AGE YOU FIRST USED: _____ DATE YOU LAST USED: _______________

MEDICAL / PSYCHIATRIC HISTORY, IF KNOWN

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

Date of Admin	Name of Hospital	City	State	Reason for Admin

CURRENT MEDICAL DIAGNOSIS OR DIAGNOSES:

_____

CURRENT PSYCHIATRIC DIAGNOSIS OR DIAGNOSES:

_____

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

1. NAME OF DOCTOR: _____

   REASON FOR SEEING: _____

2. NAME OF DOCTOR: _____

   REASON FOR SEEING: _____

ARE YOU CURRENTLY TAKING MENTAL HEALTH OR PAIN MEDICATION(S)? YES ☐ or NO ☐

MEDICATION: _____

PRESCRIBING DOCTOR: _____

MEDICATION: _____

PRESCRIBING DOCTOR: _____

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

_____ _______________

Applicant Signature Date

I understand that participation in this program is based upon meeting statutory criteria, providing and completing necessary paperwork, completion of a mental health evaluation to determine whether I suffer from a condition that is, or reasonably could be, related to my military service, and that my condition caused or contributed to the criminal offense that I have been charged with, and that the ultimate decision regarding my acceptance to the program will be made by the VTC Team. I understand that the intake interview and application to VTC does not mean that I am accepted, and therefore I must continue to follow all current bond, pretrial, and/or court ordered conditions. I understand my military service and discharge type will be verified by the Department of Veterans Affairs.

_____ _______________

Applicant Signature Date

DALLAS COUNTY VETERAN TREATMENT COURT APPLICANT VOLUNTARY WAIVER OF CONFIDENTIALITY AND CONSENT FOR DISCLOSURE OF CONFIDENTIAL INFORMATION (Disclosure with client's consent as per Title 42, Chapter 1, Part 2 Federal Register)

I, _____, voluntarily waive my rights of confidentiality and authorize all Dallas County Community Supervision and Corrections Department personnel and VETERANS TREATMENT COURT staff to request and receive information or records from any person including myself, or any agency having information or records concerning my medical, psychological, or psychiatric history and any information or records pertaining to diagnosis, condition or treatment of a medical, psychological or psychiatric nature including acquired immune deficiency syndrome (AIDS), human immunodeficiency virus (HIV), or any AIDS related complex as necessary in order to facilitate my voluntary involvement in the Dallas County VETERANS TREATMENT COURT PROGRAM.

The VETERANS TREATMENT COURT PROGRAM Staff includes the Presiding Judge, the Criminal District Attorney or his designated Assistant Criminal District Attorney, the Chief Public Defender or her designated Deputy Public Defender, designated Officers of the Community Supervision Department including supervisors and health care professionals, and employees of the United States Department of Veterans Affairs (VA) and of the Veterans Benefits Administration (VBA).

I further waive my rights of confidentiality and authorize any agency, doctor, hospital or treatment facility to disclose any and all information or records requested by any Dallas County Community Supervision and Corrections Department personnel or VETERANS TREATMENT COURT PROGRAM staff as deemed necessary by the VETERANS TREATMENT COURT PROGRAM staff to facilitate treatment and care or to monitor my participation in VETERANS TREATMENT COURT PROGRAM.

I further waive my rights of confidentiality and authorize Dallas County Community Supervision and Corrections Department personnel and VETERANS TREATMENT COURT staff to disclose any and all acquired information or records to the following:

1. The Judge having authority over my case and the personnel of the Court.
2. Other Dallas County Community Supervision and Corrections Department personnel involved in the supervision and maintenance of my supervision file.
3. Personnel of any department to which my case may be transferred for supervision.
4. Personnel of any residential treatment facility in which I may be placed, including the Dallas Community Judicial Treatment Center.
5. Personnel of any institution/facility to which I may be committed.
6. Personnel of any treatment/diagnostic program to which I may be assigned.
7. Personnel from the District Attorney's Office assigned specifically to the VTC, but no other District Attorney's Office personnel.
8. My attorney of record.
9. Janie Martin, attorney for the Dallas County Veterans Treatment Court.
10. Texas Department of Criminal Justice, Community Justice Administrative Division.
11. The United States Department of Veterans Affairs.

This waiver is limited to communication made to and among the persons or agencies referenced above and I do not waive my rights of confidentiality in regards to any other individual or agency not so included. I understand the purpose of this waiver is to facilitate the supervision of my case and I may revoke this waiver at any time. If not earlier revoked by me, this waiver expires thirty (30) days after my graduation from the Veterans Treatment Court Program (resulting in the dismissal of criminal charges before the Veterans Treatment Court Program or immediately upon my voluntary or involuntary termination from Veterans Treatment Court Program prior to successful completion.

I understand that my records are protected by the Code of Federal Regulations; Part 2 of Title 42 governing confidentiality of alcohol and drug abuse client records and that recipients of this information may disclose it within the agreement of this signed agreement.

I understand one purpose of, and need for, this disclosure is to inform the court and all other named parties of my eligibility and/or acceptability for substance abuse treatment services and my treatment attendance, prognosis, compliance and progress in accordance with the VETERANS TREATMENT COURT monitoring criteria. This information may be released through verbal, written or electronic communication.

I understand that this consent will remain in effect and cannot be revoked by me until there has been a formal and effective termination of my involvement with the VETERANS TREATMENT COURT for the above referenced case(s), such as the discontinuation of all supervision and/or, where relevant, dismissal off the charges and/or, where relevant, the assignment of this case to a division other than the VETERANS TREATMENT COURT. I understand that any disclosure made is bound by Part 2 of Title 42 of the Code of Federal Regulations, which governs the confidentiality of substance abuse patient records and that recipients of the information may re-disclose it only in connection with their official duties.

I have read or have had read to me the terms and conditions of this agreement and fully understand same. I do hereby, freely, knowingly, and intelligently agree to those terms and conditions.

_____ _______________

Veteran (Print Name) Date

_____

Veteran (Signature)

_____ _____

Name of Attorney for Veteran (Print Name) Texas Bar Number

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 information needed 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 the provision of treatment, payment, enrollment in the VA Health Care Program, or eligibility for benefits on the signing of an authorization, except for research-related treatment where an authorization for the use or disclosure of individually-identifiable health information for such research is required. 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 24VA10A7 "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)*

VA North Texas Health Care System, 4500 S. Lancaster, Dallas, TX 75216 and any other VHA hospital system (including Vet Centers) where the Veteran has or will receive services. _____

LAST NAME- FIRST NAME- MIDDLE NAME LAST 4 SSN:	DATE OF BIRTH *(mm/dd/yyyy)*

PATIENT'S MAILING ADDRESS (*including City, State and Zip Code*)

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL, OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

Dallas Co. VTC, 133 N. Riverfront Blvd., Dallas, TX 75207. VBA; VSOs; Correctional Staff; Community Supervision Officers; Jail/Court Mental Health Diversion Staff; Veterans Court to include: Judge, Staff, Team, Guests, and all Officers of the Court.

_____ INITIAL HERE in ink

PURPOSE(S) OR NEED: Information is to be used by the requestor 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)*: All mental health, medical, & substance abuse notes.
- ☐ SPECIFIC PROVIDERS *(Name & Date Range)*: _____
- ☐ DATE RANGE: _____

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

☒ LAB RESULTS:

- ☒ SPECIFIC TESTS *(Name & Date)*: Drug utox screens past & future deemed relevant by court.
- ☐ DATE RANGE: _____

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

☒ LIST OF ACTIVE MEDICATIONS: _____

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

☒ OTHER *(Describe)*: Appt information,problem list,& all relevant medical information needed.

LAST NAME- FIRST NAME- MIDDLE NAME LAST 4 SSN:	DATE OF BIRTH *(mm/dd/yyyy)*

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.

[X] DRUG ABUSE [X] ALCOHOLISM OR ALCOHOL ABUSE [X] SICKLE CELL ANEMIA

[X] HUMAN IMMUNODEFICIENCY VIRUS *(HIV)* *Please initial here to acknowledge the selections made in this section* X _____ INITIAL HERE in ink

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 *(select one of the following)*:

[ ] AFTER ONE-TIME DISCLOSURE, IF ALL NEEDS ARE SATISFIED

[ ] ON *(mm/dd/yyyy)* _____ *(enter a future date other than date signed by patient)*

[X] UNDER THE FOLLOWING CONDITION(S): 1.Written revocation submitted to VA staff. 2.Written verification from court that VA recs are no longer required. 3.Upon court completion.

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, fax, and/or secured email that is required by the court for monitoring of Veteran treatment progress and compliance. Data will be inclusive of all relevant medical record information, but not to be limited to: diagnoses (medical, mental health, & substance abuse), relevant labs, progress in treatment programming, developmental, social, financial, & military data relevant to court/legal circumstances. Information will be shared at regular intervals, as needed by the court team to adequately assess progress of Veteran and compliance with court guidelines. Medical record information is subject to review in open court.

DATE RELEASED *(mm/dd/yyyy)*	RELEASED BY:

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 information needed 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 the provision of treatment, payment, enrollment in the VA Health Care Program, or eligibility for benefits on the signing of an authorization, except for research-related treatment where an authorization for the use or disclosure of individually-identifiable health information for such research is required. 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 24VA10A7 "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)*

VA North Texas Health Care System
4500 S. Lancaster
Dallas, TX 75216

LAST NAME- FIRST NAME- MIDDLE NAME	DATE OF BIRTH *(mm/dd/yyyy)*
LAST 4 SSN:	

PATIENT'S MAILING ADDRESS (*including City, State and Zip Code*)

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL, OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

Kate Mann, MS, LPC/Dallas Co. Veterans Treatment Court, Crowley Courts Bldg., Community Supervision Dept., 8th fl., ATRS Dept., 133 N. Riverfront Blvd., Dallas, TX 75207; fax: 214-653-2874.

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

☐ TREATMENT ☐ BENEFITS ☒ LEGAL ☐ EMPLOYMENT ☒ OTHER *(Please specify)* Continuity; tx status

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)*: All mental health, medical, & substance abuse notes.
- ☐ SPECIFIC PROVIDERS *(Name & Date Range)*: _____
- ☐ DATE RANGE: _____

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

☒ LAB RESULTS:

- ☒ SPECIFIC TESTS *(Name & Date)*: Medication and drug/alcohol urinalysis.
- ☐ DATE RANGE: _____

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

☒ LIST OF ACTIVE MEDICATIONS: _____

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

_____

☒ OTHER *(Describe)*: All records

LAST NAME- FIRST NAME- MIDDLE NAME LAST 4 SSN:	DATE OF BIRTH *(mm/dd/yyyy)*

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

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[X] HUMAN IMMUNODEFICIENCY VIRUS *(HIV)* _____ INITIAL HERE in ink

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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 *(select one of the following)*:

[ ] AFTER ONE-TIME DISCLOSURE, IF ALL NEEDS ARE SATISFIED

[ ] ON *(mm/dd/yyyy)* _____ *(enter a future date other than date signed by patient)*

[X] UNDER THE FOLLOWING CONDITION(S): 1.Written revocation submitted to VA staff. 2.Written verification from court that VA recs are no longer required. 3.Upon court completion.

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

Continuity of care; current treatment status/adherence; records can be faxed/mailed.

DATE RELEASED *(mm/dd/yyyy)*	RELEASED BY:

VETERAN APPLICANT QUESTIONNAIRE

**Please add an extra page after this page in the application packet referencing the question number if you need additional space.*

1. Please explain in your own words how you believe your experiences during your military service contributed to the behavior resulting in this arrest:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

2. The Dallas County Veterans Treatment Court is a treatment court designed to address mental health conditions (psychiatric, substance abuse, cognitive impairments, et al.) arising from experiences during military service. Please explain how your military service has resulted in a mental health and/or substance abuse condition which may be addressed through treatment.

_____

_____

_____

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_____

3. Why do you wish to participate in the Veterans Treatment Court, and what do you hope to achieve through participation?

_____

_____

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Thank you for your application to Dallas County Veterans Treatment Court and thank you for your service to our great nation!