

LAWRENCE COUNTY TREATMENT COURT – RECONSIDERATION FORM

Please use this form for individuals who have been formally rejected from Treatment Court or for whose original application is older than 6 months. Reconsideration form must be completed in its entirety, along with all attached releases. Incomplete forms will be returned to the attorney of record and may delay the review/admissions process. For questions, contact the Treatment Court Coordinator by calling (724) 614-1113.

LEGAL REPRESENTATION

Attorney Name:

☐ Public Defender ☐ Private/Court Appointed

CRIMINAL/CHARGE INFORMATION -- TO BE COMPLETED BY DEFENSE ATTORNEY

PLEASE LIST ALL OTNS FOR WHICH YOUR CLIENT IS APPLYING FOR TREATMENT COURT:

Do any of the cases include use or possession of a weapon? ☐ Yes ☐ No

APPLICANT INFORMATION

Name: <i>First</i> <i>Middle</i> <i>Last</i>			Alias/Maiden:	
Physical Address: <i>Street</i>		<i>City</i>	<i>State</i>	<i>Zip Code</i>
Mailing Address: <i>Street</i> <i>Same as Above</i> <input type="checkbox"/>		<i>City</i>	<i>State</i>	<i>Zip Code</i>
County of Residence:		Currently on Prob/Parole: <input type="checkbox"/> Yes <input type="checkbox"/> No		
		If yes, where? Officer?		
Home Phone: ()		Cell: ()		Other: ()
Email:		Primary source of transportation:		
If female, are you pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes – Due Date:				Physician:

EMPLOYMENT AND HOUSING STATUS

Employment Status (select one):				
<input type="checkbox"/> Unemployed	<input type="checkbox"/> Employed Full-Time (35+ hours/week)	<input type="checkbox"/> Volunteer		
<input type="checkbox"/> Retired	<input type="checkbox"/> Employed Part-Time (<35 hours/week)	<input type="checkbox"/> Disabled		
Employer:		Address:		
Start Date:		Occupation:		
Housing Status:	<input type="checkbox"/> Independent	<input type="checkbox"/> Dependent	<input type="checkbox"/> Incarcerated	<input type="checkbox"/> Homeless

SUBSTANCE ABUSE HISTORY	
1	2
3	4
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99	100

Have you ever abused drugs or alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No	Currently using? <input type="checkbox"/> Yes <input type="checkbox"/> No
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If no to either of the above, move on to the next section. If yes to either of the above, please complete the following:

Frequency of recent use:			
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Are you currently in any level of treatment? ☐ No ☐ Yes, where? Level of care:

Are you currently prescribed interventions	<input type="checkbox"/> Yes	If yes, list medication(s):
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(MATs) for substance abuse?	<input type="checkbox"/> No	Prescribing Provider:
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MENTAL HEALTH HISTORY	
1	Presenting problem
2	History of present illness
3	History of past illness
4	Family history
5	Personal history
6	Substance use
7	Current medications
8	Previous treatments
9	Current symptoms
10	Thoughts
11	Mood
12	Insight
13	Judgment
14	Compliance
15	Support system
16	Stressors
17	Triggers
18	Protective factors
19	Resilience
20	Coping mechanisms
21	Self-harm
22	Suicidal thoughts
23	Aggression
24	Paranoia
25	Delusions
26	Hallucinations
27	Obsessive-compulsive
28	Phobias
29	Specific phobias
30	Generalized anxiety
31	Major depressive disorder
32	Bipolar disorder
33	Schizophrenia
34	Personality disorders
35	Borderline personality disorder
36	Narcissistic personality disorder
37	Antisocial personality disorder
38	Obsessive-compulsive disorder
39	Compulsive disorder
40	Post-traumatic stress disorder
41	Acute stress disorder
42	Adjustment disorder
43	Substance use disorders
44	Alcohol use disorder
45	Drug use disorder
46	Dependence
47	Withdrawal
48	Tolerance
49	Cravings
50	Relapse
51	Recovery
52	Relapse prevention
53	Aftercare
54	Continued care
55	Long-term management
56	Prognosis
57	Outlook
58	Summary
59	Recommendations
60	Follow-up
61	Referrals
62	Consultations
63	Collaborative care
64	Integrated care
65	Whole-person care
66	Preventive care
67	Health promotion
68	Behavior change
69	Self-management
70	Empowerment
71	Participation
72	Shared decision-making
73	Patient-centered care
74	Person-centered care
75	Individualized care
76	Customized care
77	Personalized care
78	Targeted care
79	Precision medicine
80	Genomic medicine
81	Digital medicine
82	Telemedicine
83	Remote care
84	Virtual care
85	Online care
86	Mobile care
87	Wearable devices
88	Health monitoring
89	Health tracking
90	Health data
91	Health information
92	Health records
93	Health data management
94	Health data analysis
95	Health data visualization
96	Health data security
97	Health data privacy
98	Health data governance
99	Health data stewardship
100	Health data leadership

Have you been diagnosed by a medical professional with a mental health disorder? ☐ No ☐ Yes, when?

If yes, who diagnosed you?	Disorder(s) diagnosed?
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Are you prescribed any mental health medications? <input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, list medications:
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REASON(S) FOR RECONSIDERATION
This section is to be completed by the defendant and should include any supportive reasoning for reconsideration.

<p><i>This section is to be completed by the defendant and should include any supportive reasoning for reconsideration.</i></p>	
<p></p>	

[illegible]

RE-APPLICANT NAME: _____

Signify your acknowledgement and acceptance to the following statements by initialing in the spaces provided.

- _____ 1. I understand and agree to execute all Consents to Release Confidential Information to the Drug Treatment Team regarding any present or past Substance Abuse Treatment Programs, Medical Treatment, Prescribed Medication, and/or any other information the Treatment Court Team may require.
- _____ 2. I understand and acknowledge that this application is for reconsideration for admission into the Treatment Court Program, and, until I receive notice of acceptance or rejection into the Treatment Court Program, I will continue to appear at all scheduled proceedings in my case(s).
- _____ 3. I understand and acknowledge that upon acceptance into the Treatment Court Program, this case will be continued generally pending the successful completion or termination of my Treatment Court Treatment Program.
- _____ 4. I understand and acknowledge that should my application be rejected, my case(s) shall continue through the normal criminal procedure process.
- _____ 5. I understand and acknowledge if my application for reconsideration is rejected, I may not be given re-consideration on the case(s) for which I am applying.
- _____ 6. I understand that upon acceptance I will comply with all the requirements of the Lawrence County Court of Common Pleas Treatment Court Program including *but not limited to*: attending court sessions, reporting as directed to probation, engaging with case management, random drug testing, attending peer support meetings, community service, attended appropriate level(s) of care for drug & alcohol and/or mental health treatment.
- _____ 7. I understand that the Treatment Court program requires a minimum commitment of 18-24 months but may be longer depending on my individual progress in the phases of the program.

The facts set forth in the 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.

Signature of Applicant for Reconsideration

Date

DO NOT COMPLETE THIS SECTION – OFFICIAL COORDINATOR USE ONLY		
Date(s) Distributed for Review		
Received:	DA:	SCA/VJO: