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

EMPLOYMENT AND HOUSING STATUS		
Employment Status (select one):		
☐ Unemployed	☐ Employed Full-Time (35+ hours/week)	☐ Volunteer
☐ Retired	☐ Employed Part-Time (<35 hours/week)	☐ Disabled
Employer:	Address:	
Start Date:	Occupation:	
Housing Status: ☐ Independent	☐ Dependent ☐ Incarcerated	☐ Homeless

SUBSTANCE ABUSE HISTORY			
Have you ever abused drugs or alcohol? ☐ Yes ☐ No		Currently using? ☐ Yes ☐ No	
If no to either of the above, move on to the next section. If yes to either of the above, please complete the following:			
Drug(s) of Choice:	*1st*	*2nd*	*3rd*
Frequency of recent use:			
Date of last use:			
Are you currently in any level of treatment? ☐ No ☐ Yes, where?		Level of care:	
Are you **currently** prescribed interventions (MATs) for substance abuse? ☐ Yes ☐ No		If yes, list medication(s):	
		Prescribing Provider:	

MENTAL HEALTH HISTORY	
Have you been diagnosed by a medical professional with a mental health disorder? ☐ No ☐ Yes, when?	
If yes, who diagnosed you?	Disorder(s) diagnosed?
Are you prescribed any mental health medications? ☐ No ☐ Yes	If yes, list medications:

REASON(S) FOR RECONSIDERATION
This section is to be completed by the defendant and should include any supportive reasoning for reconsideration.

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:*