FOURTH JUDICIAL DISTRICT VETERANS TREATMENT COURT APPLICATION

Date of Application	Please submit completed application to the Fourth Judicial District Veterans Treatment Court Prosecutor, Paul Forney. Submit by E-mail: Paul.Forney@pottcounty-ia.gov. or Fax-712-328-5753 or in person to the County Attorney's Office, Pottawattamie County Courthouse, 227 South 6th Street, 5th Floor, Council Bulffs, IA 51501.

Name (Last, First, Middle)	Race	Sex	Date of Birth

Current Address (Street)	Telephone Number	Cell Phone Number

City	State	Zip	How Long at this Address?

County of Residence:	Reliable Transportation ☐ Yes ☐ No	Valid Driver's License ☐ Yes ☐ No

Marital Status:	Do You Have Children? ☐ Yes ☐ No	Live with/relationship:

Emergency Contact	Relationship	Telephone Number

Current Employer	Monthly Income	Receiving Disability? ☐ Yes ☐ No

Education ☐ GED ☐ High School Diploma ☐ College Graduate ☐ Vocational Training

On Probation Currently ☐ Yes ☐ No	Probation Officer

Current Charges: Offense Date:	In Custody ☐ Yes ☐ No Where:

Do you have any matters pending in any other court? ☐ Yes ☐ No If yes, name of court:	Charges:

VA Assessment Completed ☐ Yes ☐ No	If so, where/when?

Do you now or have you ever received services from the US Department of Veterans Affairs? ☐ Yes ☐ No
If so, when and where:

Armed Forces Veteran? ☐ Yes ☐ No	Branch	Dates of Service **(Attach DD214)**	Discharge Type/Date:

Were you deployed to a combat zone or hazardous duty? ☐Yes ☐ No	If yes, when and where:

Have you been treated for/diagnosed with PTSD, a service related mental disorder or a traumatic brain injury (TBI) ☐Yes ☐ No	If yes, explain:

Defense Attorney Name	Telephone Number

"The defendant consents to the disclosure of Veteran Court application information, including a Risk/Needs Assessment and a Treatment Needs Assessment, prior to entry of a plea, for purposes of obtaining information useful for acceptance into the Veteran Court Program." ***I wish to apply to the Pottawattamie County Veterans' Treatment Court.***

_____	_____	_____	_____
Applicant Signature	Date	Defense Attorney Signature	Date

Interagency Release of Information Form

AUTHORIZATION FOR DISCLOSURE AND RELEASE OF MEDICAL, MENTAL HEALTH, SUBSTANCE ABUSE, AND/OR CORRECTIONS INFORMATION

Applicant/Participant_____Birthdate_____

I, the undersigned, authorize each of the agencies initialed below whose purpose is to coordinate the services and treatment of participating clients/patients with involvement in mental health, substance abuse, and corrections conditions:

_____ **Omaha Vet Center,** 3047 S. 72nd St Suite 1, Omaha, NE 68124
_____ **Heartland Family Services (**all services and locations), 515 E. Broadway, Council Bluffs, IA 51503
_____ **Jennie Edmundson Hospital,** 933 E. Pierce St, Council Bluffs, IA 51503
_____ **Mercy/CHI Hospital,** 800 Mercy Dr., Council Bluffs, IA 51503
_____ **CHI Health Psychiatric Associates,** 801 Harmony St, Suite 302, Council Bluffs, IA 51503
_____ **Pottawattamie County Community Services**, 515 5th Ave, Suite 113, Council Bluffs, IA 51503
_____ **Southwest Iowa MHDS Region,** 515 5th Ave, Suite 113, Council Bluffs, IA 51503
_____ **Pottawattamie County Sheriff's Office,** 1400 Big Lake Rd., Council Bluffs, IA 51501
_____ **Pottawattamie County Jail,** 1400 Big Lake Rd, Council Bluffs, IA 51501
_____ **Council Bluffs Police Dept.,** 227 S. 6th St, Council Bluffs, IA 51501
_____ **Department of Corrections, Adult Probation,** 801 S. 10th St, Council Bluffs, IA 51501
_____ **PDO or attorney of record; County Attorney; and other member of VTC team**
_____ **Lasting Hope Recovery Center**, 415 S. 25th Omaha NE 68131
_____ **Collaborative Support Team,** 515 5th Ave, Suite 113, Council Bluffs, IA 51503
_____ **Heartland Bridges,** 600 9th Ave, Council Bluffs, IA 51503
_____ **Other:_____(**family member and/or significant other must include address**)**
_____ **Other:_____(**must include name and/or agency and address**)**
_____ **All of the Above Providers**

To disclose verbally and/or to release in writing to any and all of the participating agencies initialed above, the following information pertaining to the evaluation and/or treatment of the above-named client/patient: (please checkmark)

_____ **Attendance and Compliance**
_____ **Discharge Summary**
_____ **History and Physical**
_____ **Medical/Health**
_____ **Lab, X-Ray, EKG**
_____ **Progress Notes**
_____ **Diagnosis & Assessment (for both mental/substance)**
_____ **Insurance coverage/funding sources**
_____ **Emergency Room Report**
_____ **Pathology Report**
_____ **Consultations**
_____ **Educational records**
_____ **Other information as needed (specify)**
_____
_____ **On-going progress communication**

This information is to be used for the coordination of the applicant/participant's mental health, substance abuse, and corrections conditions. This information is gathered for the purpose of evaluating criteria for admission into Veterans Treatment Court (VTC); preparing a case plan for VTC and to check progress and compliance with the terms of VTC. I understand that re-disclosure of this information by the authorized participating agencies is prohibited, except as permitted by applicable federal and state laws. Once the requested information has been disclosed, the recipient of the information may re-disclose it and the privacy regulations guaranteed with this consent to release information, may no longer protect the information. However, filings with the Clerk of Court will have a level of security to prevent public access.

This authorization will automatically expire in twelve (12) months from the date of my signature, except as hereby specified: _____(list specific number of days or months). At that time, no express revocation shall be needed to terminate my consent, but I understand that I may revoke this consent at any time by sending a written notice to the Director of Medical Records of each of the participating agencies whom I have authorized above. I understand that any disclosure or release of information which was made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality and that my protected health information may be subject to re-disclosure and may no longer be protected by the HIPAA privacy provisions. I further understand that I may inspect the information disclosed by any of the participating agencies by contacting the Director of Medical Records at each such agency. I understand that a medical release is normally 6 months but by my voluntary participation in Veterans Treatment Court-the supervision has a minimum of 12 months. This authorization will automatically expire upon the completion of correctional supervision (institutional or community based).

I understand that if the person or entity listed above is a physician; surgeon; physician's assistant; advanced registered nurse practitioner or mental health professional this authorization also permits _____ to consult with the provider about my medical history and condition relating to my diagnosis; evaluation; treatment; progress notes; attendance and compliance (with medication as well as other therapeutic treatment);and any other information relied upon which bears upon conditions of eligibility; conditions of care plan; or progress/compliance for the Fourth Judicial District Veterans Treatment Court.

_____ _____

Signature of Veterans Treatment Court applicant/ participant **Date**

_____

_____ **Date**

Attorney for Applicant/participant

Specific Authorization For Release Of Information

Protected by State Or Federal Law, 42 CFR Part 2

I specifically authorize the release of information relating to:

(Applicant/participant must initial appropriate line(s))

____ Substance Abuse (alcohol/drug abuse)
____ Mental Health (including psychological testing)
____ Acquired Immune Deficiency Syndrome (AIDS) including Human Immunodeficiency Virus (HIV) test results

_____
Signature/Date

In Order For The Above Information To Be Released, You Must Sign Here <u>And</u> In the Next Column.

_____
Signature of applicant/participant or Authorized Representative

_____
Relationship, if not the applicant/participant

_____
Address

_____
Date

Copy given to applicant/participant on _____(date)

by _____

Information released on _____(date)

by_____

to _____
_____