



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 Bluffs, 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 <input type="checkbox"/> Yes <input type="checkbox"/> No	Valid Driver's License <input type="checkbox"/> Yes <input type="checkbox"/> No	
Marital Status:	Do You Have Children? <input type="checkbox"/> Yes <input type="checkbox"/> No	Live with/relationship:	
Emergency Contact	Relationship	Telephone Number	
Current Employer	Monthly Income	Receiving Disability? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Education <input type="checkbox"/> GED <input type="checkbox"/> High School Diploma <input type="checkbox"/> College Graduate <input type="checkbox"/> Vocational Training			
On Probation Currently <input type="checkbox"/> Yes <input type="checkbox"/> No	Probation Officer		
Current Charges:	In Custody <input type="checkbox"/> Yes <input type="checkbox"/> No		Where:
Offense Date:	Do you have any matters pending in any other court? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of court:		Charges:
VA Assessment Completed <input type="checkbox"/> Yes <input type="checkbox"/> No	If so, where/when?		
Do you now or have you ever received services from the US Department of Veterans Affairs? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, when and where:			
Armed Forces Veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No	Branch	Dates of Service (Attach DD214)	Discharge Type/Date:
Were you deployed to a combat zone or hazardous duty? <input type="checkbox"/> Yes <input type="checkbox"/> 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) <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, explain:		
Defense Attorney Name	Telephone Number		
<p>"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.</p>			
_____ 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 | _____ Emergency Room Report |
| _____ Discharge Summary | _____ Pathology Report |
| _____ History and Physical | _____ Consultations |
| _____ Medical/Health | _____ Educational records |
| _____ Lab, X-Ray, EKG | _____ Other information as needed (specify) |
| _____ Progress Notes | _____ |
| _____ Diagnosis & Assessment
(for both mental/substance) | _____ On-going progress communication |
| _____ Insurance coverage/funding sources | |

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

Attorney for Applicant/participant

Date

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 And 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 _____
