

Guadalupe County Veterans Treatment Court Application

The Guadalupe County Veterans Treatment Court ("VTC") Participant Handbook has been read and you understand the program and what's expected of you during the course of the program?

Yes / No; if no, please read the handbook before you proceed. (circle one)

This is a treatment court, and it takes a minimum of 14 months to complete the program; which includes, but is not limited to:

- weekly Seeking Safety meetings (Wednesday evenings at the Seguin DAV) provided by mentor volunteers
- monthly appointments with your VTC probation officer a member of the VTC team
- monthly appointments with the VJO (location appointments in Seguin, NB or SA) a member of the VTC team, or private counselor
- community hours related to veteran programs
- specialized DWI, Drug, Anger Management type classes and/or therapy or classes relative to your particular case
- attending Veterans Treatment Court

By signing here, you are stating you have read the handbook and understand the rules and consequences.

	Signature	 ;
Please type or print so it is l	egible.	
Last Name:	First Name:	Middle Name:
Aliases/Maiden Name:		Male / Female
Email:	Arrest Date:	Inmate No.:
Do you have an interlock?	Yes / No; If yes; please li	ist the company:
Case (circle one): Felony	or Misdemeanor	Case No.:
Do you currently have an	attorney? Yes / No; If yes;	; name:
Is your attorney (circle on	e): Hired by You – or –	Court Appointed
Mobile Phone Number:	Alteri	nate Phone Number:
Date of Birth:	Social Se	curity No.:
Do you live in Guadalupe (County? Yes / No; If no; na	ame County of Residence:
Physical Address:		
City:	State: Texas Zip:	County:
Mailing Address (only if diffe	erent from Physical Address):	
City:	State: Texas Zip:	County:

Marital Status:	In a relations	ship? Yes / No; If yes; name:			
Who else resides in your household?					
How many children do you	have?	List all their names, age & name of other parent:			
Name:	Age	Other Parent:			
					
		-			
	_				
Emergency Contact Infor	mation:				
-		e:Relationship:			
House Phone Number:		Cell Phone:			
Physical Address:					
City:	_ State: Texas	s Zip: County:			
Military Service:					
-		Coast Guard Reserves National Guard			
Dates of Service:	to				
-		eral Under Honorable Conditions			
(Listed on DD214) Under Dishon		onorable Conditions Bad Conduct			
Highest Rank:		Rank at Discharge:			
Where did you serve?					
Have you carryed in Combat	-2 Voc / No. 1				
	15/Disciplina	f yes to combat; how many times?ary Actions/Military convictions? Yes / No (More			
Education: Highest level of education:	HS Diplom	aGEDCollegeVocational Training			
Currently enrolled in educa	ition? If so, list	t school:			

Dilver S License:		/ N			
Do you have a valid driver's license? Yes / No If no, why not?					
If yes; Driver's Licens	e No.:	State	State Issued:		
Occupation:					
Are you currently em	ployed?: Yes / No	Employer:			
Retired?: Yes / No Work Phone:		Retired from:			
		Work Ac	ldress:		
Work schedule:					
Financial Status:					
Your Monthly Income	e: \$				
List Debts:					
List Assets:					
Cubatanaa Abaa /B#	ontol Hoolth /M-J	iaal.			
Substance Abuse/M	•		\$7 / \$1		
Are you currently rec	•		•		
Have you ever previo	-		·		
Are you currently rec	_		•		
Have you ever previo	-		•		
List any existing diag				-	
Are you eligible to red			Yes / No / Don't know		
If yes, where?	-		•		
			 No If so, Disability Rating	OT.	
List Current Medicati		-	To It 30, Disability Rating	5	
Prescription name:	Dosage Ofte		or: Doctor:		
	200490 010		200011		
					
					

Should you require additional space; please write on the back or include an additional sheet.

Date:	Charge:	Place/Location:
	be additional charges; please ii	nclude all by writing on the back or including an
	l military charges or arrests the exception of traffic cita	(Article 15/Disciplinary Actions/Military tions):
Date:	Charge:	Place/Location:
Offense:		
additional she	eet.	nclude all by writing on the back or including ar ole by another court; complete the
following:	escriety on probation or part	ore by unother court, complete the
•	y:	
		Phone No.:
		y other outstanding criminal charges outside
or addudarape		
-	charges and where?	

Should there be additional court actions; please include all by writing on the back or including an additional sheet.

By signing/submitting this application, I have read or had read to me the Guadalupe County Veterans Treatment Court description and acknowledge that I will commit my time and effort to create behavioral and life changes if accepted. I have been truthful, to the best of my knowledge, with regard to all my answers in this application.

Please check the boxes and return the following completed documents:

	Completed Application
	 Typed or hand-written essay/personal statement should include, but is not limited to, the following: a. That you accepted full responsibility for your wrongdoing; b. How your disorder is connected to the events you experienced during your military service; c. How your disorder is related to the criminal offense for which you are charged; d. Your role and contributions you made to the military; e. Why you should be afforded an opportunity to participate in the VTC; f. Any other information you want to have considered;
	Participant Handbook Forms a. Receipt and Review of Participant Handbook (Page 15) b. Confidentiality Statement and Agreement (Page A-4)
	Copy of DD214 - Member 4
	Copy of military identification card; if applicable
	VA release - as an attachment to this email
	VA Medical Card (White & Blue); if applicable
Signa	Date:
Any a	additional notes you wish to include:

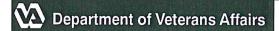
Sample instructions to please complete the attached VA Release in the following:

- Provide your full name, address and DOB (on Page 1 &2);
- Sign and date (on Page 2); and
- Please be sure you also initial these boxes (do not check them) as shown:

Department of Veterans Affairs	
	RELEASE HEALTH INFORMATION
PRIVACY ACT STATEMENT:	
Perchalty and Accommissing Act, 45 CFR Perc 160 and 144, 55 expensed on this form is voluntary. However, in fincinance need comply with the request. The Veterum Health Administration may elightize for benefits on the signing of an influencean, except to finefalls the hist informance for such research in regional VA in Toutine asset "disclosure of the informance is excluded in the Perc 107405" Employee Medical Fig. 5 system Records (Tell 8-1)-VA*	USC The form surfarmes relates of information in accordance with the Health Insurance 15 C. 515 and 18 USC 500 and 1913 that you speech. Your disclosure of the information of a locate records for believe in our firmfulned congressly and accordance. We will be made to core condition the previous of treasured payment, extrained in the VA Health Care Program. From the Whitel to insurant below as information for the use of substance of administration, the result of the substance of the surface of the surface of the substance of administration years. We have the substance of the surface of the substance of administration by Air reports of records incorns information 10 AVAIDAL "Primer Medical Execut" VAV. In the contrast of the substance of the substance of the substance of the substance of these records, and for other purposes surfaces for required by law.
TO: DEPARTMENT OF VETERANS AFFAIRS (Name and I 7400 Merton Minter Blvd. San Antonio Any other VHA hospital or outpatient	
LAST NAME - FIRST NAME - MIDDLE NAME	DATE OF BRITH (mm dd 11)
PATIENT'S MAILING ADDRESS (including City, State and	Zp Code)
PURPOSE(S) OR NEED. Information is to be used by the re ☑ TREATMENT ☐ BENEFITS ☑ LEGAL ☐	
	d state the extent or nature of information to be provided:
HEALTH SUMMARY (Prior 2 Tears)	d state the extent or nature of information to be provided:
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HUMAN IMMUNODEFICIENCY VIRUS (HIT)			
I understand that information on these sensitive du released even if the boxes are unchecked <u>unless</u> I disclosure.	agnoses may be released for treatment of the box below	ent purposes without mithat I do not want this i	e checking the above boxes, and will information released for this specific
I do not want sensitive diagnoses released other future requests unrelated to this auti	for treatment purposes under the	is specific authorizati	on. I realize this does not impact
AUTHORIZATION: I certify that this request haccurate and complete to the best of my harmfelled authorization in writing, at any time except yield be recept by the Release of Information Unit at the insustherized reductioner, and the information III indentical that the VA health care providers on	e. I understand that I will receive a extent that action has already been acting housing records. Any disclo- ny not be protected by federal confi- inions and statements are not offici-	copy of this form after taken to comply with a sure of information can deutrality rules. al VA decisions regard	I sign it I may revoke this t. Written revocation is effective upones with it the potential for ing whether I will receive other VA
benefits or, if I receive VA benefits, their amount. Remonal Office that specializes in benefit decision	They may, however, be considered	with other evidence w	ben these decisions are made at a V
EXPIRATION: Without my express revocation, the		re iselect one of the fol	low mex.
AFTER ONE-TIME DISCLOSURE, IF ALL NE			
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UNDER THE FOLLOWING CONDITION(S):			he court program and
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REQUEST FOR AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

PRIVACY ACT STATEMENT:

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.

identifiable health information for such research is required. VA may disclose the information that you put on the form as perm "routine use" disclosure of the information as outlined in the Privacy Act system of records notices identified as 24VA10A7 "P 08VA05 "Employee Medical File System Records (Title 38)-VA" and in accordance with the Notice of Privacy Practices. VA identify Veterans and person claiming or receiving VA benefits and their records, and for other purposes authorized or required	atient Medical Record - VA", may also use this information to
TO: DEPARTMENT OF VETERANS AFFAIRS (Name and Location of the VA Health Care Facility)	
7400 Merton Minter Blvd. San Antonio, TX 78229	
Any other VHA hospital or outpatient clinic where veteran is or has	received treatment.
LAST NAME- FIRST NAME- MIDDLE NAME	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	I IS TO BE RELEASED
The Guadalupe County Veterans Treatment Court - 211 W. Court Street,	
78155. All affiliated individual agencies, attorneys, and court staf	f.
PURPOSE(S) OR NEED: Information is to be used by the requestor for:	. *
▼ TREATMENT):
INFORMATION REQUESTED: Check applicable box(es) and state the extent or nature of information to be provided	d:
HEALTH SUMMARY (Prior 2 Years)	
PATIENT MEDICAL RECORDS (Dates):	2.500
INPATIENT DISCHARGE SUMMARY (Dates):	
PROGRESS NOTES:	
SPECIFIC CLINICS (Name & Date Range):	
SPECIFIC PROVIDERS (Name & Date Range):	
DATE RANGE:	
OPERATIVE/CLINICAL PROCEDURES (Name & Date):	
X LAB RESULTS:	
X SPECIFIC TESTS (Name & Date): All drug/alcohol toxicology screens past	and future
DATE RANGE:	
RADIOLOGY REPORTS (Name & Date):	
X LIST OF ACTIVE MEDICATIONS: All medications past and future	
VACCINATION (Dose, Lot Number, Date & Location):	
ADMINISTRATIVE RECORDS:	
X OTHER (Describe): All medical record information deemed relevant by VJC) past and future

LAST NAME- FIRST NAME- MIDDLE NAME			DATE OF BIRTH (mm/dd/yyyy)
SENSITIVE DIAGNOSES: REVIEW AND, IF APPROPORT OTHER THAN TREATMENT.	PRIATE, COMPLETE WHEN RE	LEASE IS FOR ANY P	JRPOSE
I request and authorize Department of Veterans Affairs listed in this authorization.	to release the information pertain	ning to the condition(s) b	pelow for the non-treatment purpose(s)
DRUG ABUSE ALCOHOLISM OR ALCOHOLISM	OHOL ABUSE SICKLE	CELL ANEMIA	
HUMAN IMMUNODEFICIENCY VIRUS (HIV)			
I understand that information on these sensitive diagnor released even if the boxes are unchecked <u>unless</u> I indic disclosure.	ses may be released for treatmentate by checking the box below the	nt purposes without me on at I do not want this info	checking the above boxes, and will be ormation released for this specific
I do not want sensitive diagnoses released for other future requests unrelated to this authorize	treatment purposes under this cation.	specific authorization	ı. I realize this does not impact
AUTHORIZATION: I certify that this request has be accurate and complete to the best of my knowledge. I authorization in writing, at any time except to the extereceipt by the Release of Information Unit at the facili unauthorized redisclosure, and the information may not	understand that I will receive a count that action has already been to ty housing records. Any disclosi	opy of this form after I ken to comply with it. ire of information carrie	sign it. I may revoke this Written revocation is effective upon
I understand that the VA health care provider's opinion benefits or, if I receive VA benefits, their amount. The Regional Office that specializes in benefit decisions.	y may, however, be considered	with other evidence who	en these decisions are made at a VA
EXPIRATION: Without my express revocation, the auth	orization will automatically expire	(select one of the follo	wing):
AFTER ONE-TIME DISCLOSURE, IF ALL NEEDS	ARE SATISFIED		
ON (mm/dd/yyyy) (enter a fi	ıture date other than date signed	l by patient)	
■ UNDER THE FOLLOWING CONDITION(S): Upc associated supervision, which			
PATIENT SIGNATURE (Sign in ink)			DATE (mm/dd/yyyy)
,			
LEGAL REPRESENTATIVE SIGNATURE (if applicable	e) (Sign in ink)		DATE (mm/dd/yyyy) DATE (mm/dd/yyyy)
,	e) (Sign in ink)		DATE (mm/dd/yyyy)
LEGAL REPRESENTATIVE SIGNATURE (if applicable	e) (Sign in ink) FOR VA USE ONLY	1	DATE (mm/dd/yyyy)
LEGAL REPRESENTATIVE SIGNATURE (if applicable		1	DATE (mm/dd/yyyy)
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VA FORM 10-5345, OCT 2023



Guadalupe County Veterans Treatment Court Participant Handbook

Receipt and Review of Participant Handbook

Name:	Cause No.:
I,, ackno	wledge the receipt of the Guadalupe County
Veterans Treatment Court Participant Handbook. By	my signature below, I attest that I have been
provided with a copy of the Participant Handbook	and that I have reviewed it prior to agreeing
to participate in the Veterans Treatment Court. Fo	urthermore, I acknowledge that I have been
made aware of the Veterans Treatment Court prog	ram rules and my responsibilities.
Participant Signature	-
	_
Participant Printed Name	
Date	
Date	•
Defense Attorney Signature	
Delense Attorney signature	

Guadalupe County Veterans Treatment Court Participant Handbook

Confidentiality Statement and Agreement

	I. as a participant, team member, or
to the	I,, as a participant, team member, or of the Guadalupe County Veterans Treatment Court (VTC), duly recognize my responsibility confidentiality of all of the information, data and findings derived as a function of or on of VTC and its activities. Accordingly, I hereby agree that:
Denan	or the and its detivities. Accordingly, Thereby agree that:
1.	Any information discussed at a VTC staffing shall remain confidential and will not be revealed or disseminated to anyone who is not a member of the VTC Team;
2.	Names, addresses, contact information, and/or other identifying information of program participants shall remain confidential and will not be revealed or disseminated to anyone who is not a member of the VTC Team;
3.	Unless the information reasonably relates to the commission of a new or different offense, any information garnered, obtained, or derived as a function of or on behalf of VTC and its activities shall remain confidential and will not be revealed or disseminated to anyone who is not a member of the VTC Team;
4.	All information, data, and findings contained in VTC files shall remain confidential and will not be revealed or disseminated to anyone that is not a member of the VTC Team; and
5.	It is understood that arrest warrants, supporting affidavits, or other information required by law to be public information or to be maintained for statistical purposes is not confidential.
	Date: Signed:
	Printed Name:

This form is intended to comply with requirements of Title 42 of the Code of Federal Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records.