

**GREEN LAKE COUNTY
TREATMENT COURT APPLICATION/REFERRAL FORM**

Applicant Name: _____
FirstM.I.Last

Address: _____

Application Date: _____ Referred By: _____

Aliases (other names you are known by or have used): _____

Previous Participation in Green Lake County Treatment Court? YES NO

PLEASE NOTE:

If you do not meet the following criteria, your application will not be processed and you will be automatically excluded:

1. The Applicant **must** be charged with a felony offense.
2. The Applicant **must** have pending charge(s) for a substance abuse offense or the underlying charge(s) must be motivated by substance abuse.
3. The Applicant **must** be a Green Lake County resident.
4. The Applicant **must** currently have a severe Substance Use Disorder.
5. The Applicant does **not** have any prior violent felony convictions in WI or any other state.

**You must fill out this form in its entirety. When completed, you must submit this form to:
Green Lake County Health and Human Services; 571 County Road A – PO BOX 588, Green Lake, WI 54941
ATTENTION: Treatment Court Coordinator**

APPLICANT INFORMATION:

Contact Phone #: _____ Date of Birth: _____ SS#: _____

Race: _____ Hispanic? YES NO Gender Identity: _____

Primary Language: _____ Interpreter needed? YES NO Marital Status: _____

Highest Level of Education: _____ High School Graduate? YES NO

Employment Status (include shift/work hours): _____

Are you a Veteran? YES NO If yes, Dates Served: _____ Branch: _____

Discharge: _____

Insurance: _____ Guarantor/Relationship: _____

Do you have any children? YES NO If yes, please provide ages: _____

Type of Housing: _____ How long have you lived in Green Lake County? _____

Who do you live with currently? (include name and relationship to you):

_____	_____
Name	Relationship to you
_____	_____
Name	Relationship to you
_____	_____
Name	Relationship to you
_____	_____
Name	Relationship to you
_____	_____
Name	Relationship to you

Current Alcohol and/or Drug Abuse (AODA) Treatment:

_____	_____
Location	Provider Name

Previous AODA Treatment (e.g. detox, residential, outpatient)

_____	_____	_____
Location	Provider Name	Approximate Dates
_____	_____	_____
Location	Provider Name	Approximate Dates
_____	_____	_____
Location	Provider Name	Approximate Dates

Current Mental Health Treatment: _____
Location Provider Name

Previous Mental Health Treatment (e.g. hospitalization, residential, outpatient):

_____	_____	_____
Location	Provider Name	Approximate Dates
_____	_____	_____
Location	Provider Name	Approximate Dates

Date of arrest (if applicable): _____

Current/Pending Charges: _____

Case Number and Branch: _____

If ATR, Current Conviction: _____

Next Scheduled Court Date: _____

Type of Hearing (Pre-Trial, Trial Sentencing): _____

Supervision Status: _____ Agent: _____
(RISK LEVEL)

List any general health issues or concerns:

ESSAYS

1. Please explain how your current charges/behavior is related to your substance use:

2. Explain your reasons for wanting to participate in Treatment Court at this time.

I, _____, understand and agree that if I am accepted into the Green Lake County Treatment Court Program, I will comply with the Treatment Court Conditions/Terms of Participation. Upon sentencing, I must agree to a length of probation of **at least** 18 months; I must sign all Releases of Information, as requested by the Treatment Court. If I am not accepted into the program, the information in this application may not be used against me in any criminal or revocation proceeding. By signing this I also confirm I have never been convicted of a violent felony offense in WI or any other state.

Signature of Defendant

Date

Referring source/**Print Name**

Signature

Date

Mailing Address and Contact # for Defendant's Counsel

Contact #: _____

Address: _____

PLEASE COMPLETE ALL AUTHORIZATIONS TO RELEASE INFORMATION & SEND WITH APPLICATION