



Unified Judicial System

Sixth Circuit Treatment Court Application

Return to: Treatment Court Coordinator Nicholas Wiebe at Nicholas.Wiebe@ujs.state.sd.us or
Court Services, PO Box 454, Fort Pierre, SD 57532.

Date of Application:		Referring Party:	
Disability accommodations? <input type="checkbox"/> No <input type="checkbox"/> Yes		Accommodations Needed:	
Interpreter needed? <input type="checkbox"/> No <input type="checkbox"/> Yes		Language Needed:	
Full Name:		Date of Birth:	
Other Names Used:		Gender:	
Race:		Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown	
Phone Number:		Email Address:	
Current living arrangements: <input type="checkbox"/> Own <input type="checkbox"/> Rent <input type="checkbox"/> Hotel/Motel <input type="checkbox"/> With Friend/Family <input type="checkbox"/> Jail <input type="checkbox"/> Homeless			
Address:			
City:		State:	Zip Code:
Next of Kin:		Relationship:	
Address:		Phone Number:	
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Co-Habiting			
Significant Other:			
Address:		Phone Number:	
Pregnant: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Yes-Significant Other		Paying Child Support: <input type="checkbox"/> N/A <input type="checkbox"/> No <input type="checkbox"/> Yes	
Number of Children Under Age 18:		Number of Children Over Age 18:	
Children			
Full Name:	Date of Birth:	Full Name	Date of Birth:
Other Members of the Household			
Full Name:	Full Name:	Full Name:	
Driver's License Status: <input type="checkbox"/> None <input type="checkbox"/> Expired <input type="checkbox"/> Revoked <input type="checkbox"/> Suspended <input type="checkbox"/> Valid <input type="checkbox"/> ID ONLY			
Driver's License Number:		State:	
State ID Number:		State:	
Highest Grade Completed:		<input type="checkbox"/> High School Diploma <input type="checkbox"/> GED <input type="checkbox"/> College Degree	

Service the Military or Armed Forces? <input type="checkbox"/> No <input type="checkbox"/> Yes		Received Veterans Services? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Branch:		Discharge Date:	
Rank at Discharge:		Discharge Reason:	
Primary Source of Income:		Monthly Income: \$	
Employer:		Supervisor:	
Address:		Phone Number:	
Insurance: <input type="checkbox"/> No <input type="checkbox"/> Yes	Insurance Company and policy number:		
Assistance/Benefits: <input type="checkbox"/> None <input type="checkbox"/> WIC <input type="checkbox"/> TANF <input type="checkbox"/> VA <input type="checkbox"/> LIEAP <input type="checkbox"/> Child Support <input type="checkbox"/> SSI SSD <input type="checkbox"/> Voc Rehab <input type="checkbox"/> Unemployment <input type="checkbox"/> Food Stamps <input type="checkbox"/> Housing Assistance <input type="checkbox"/> Other <input type="checkbox"/> Medicaid (provide number): <input type="checkbox"/> Medicare Part A/B/C/D (provide part and number):			
Drugs of Choice: 1) 2) 3)			
Current IV Drug Use: <input type="checkbox"/> No <input type="checkbox"/> Yes		History of IV Drug Use: <input type="checkbox"/> No <input type="checkbox"/> Yes	
History of Overdose: <input type="checkbox"/> No <input type="checkbox"/> Yes		Drug of Overdose:	Date of Overdose:
Previous Treatment:	<input type="checkbox"/> None <input type="checkbox"/> Detox <input type="checkbox"/> Inpatient <input type="checkbox"/> IOP <input type="checkbox"/> Outpatient <input type="checkbox"/> Jail-Based <input type="checkbox"/> Individual <input type="checkbox"/> Co-Occurring <input type="checkbox"/> Inpatient Mental Health <input type="checkbox"/> Outpatient Mental Health		
Currently in Treatment: <input type="checkbox"/> No <input type="checkbox"/> Yes		Where:	
Treatment Needs Assessment completed within the past 6 months: <input type="checkbox"/> No <input type="checkbox"/> Yes			
Mental Health Provider:		Medical Provider:	
List all MENTAL HEALTH diagnoses:		List all MEDICAL conditions:	
List all MENTAL HEALTH medications:		List all MEDICAL medications:	
Age of First Arrest:		Gang Affiliation:	
Number of lifetime MISDEMEANOR arrests:		Number of lifetime FELONY arrests:	
Number of lifetime MISDEMEANOR convictions:		Number of lifetime FELONY convictions:	
Current Charges:			
Defense Attorney:			
Are you currently on probation? <input type="checkbox"/> No <input type="checkbox"/> Yes (Mark yes if currently on probation in South Dakota, another state and/or tribal or federal probation.)		Probation Officer: Office Location: Probation start date:	
Previous Treatment Court Participation? <input type="checkbox"/> No <input type="checkbox"/> Yes		Court:	When:
Have you ever been sentenced to prison: <input type="checkbox"/> No <input type="checkbox"/> Yes		When:	

The Treatment Court Team will determine whether you are eligible for the program. **By signing this application, you agree to allow team members to share your information (for eligibility purposes) before you plead guilty.** The information shared will include the application (signed by you and your defense attorney), the results of a risk and needs assessment (LSI-R/IDA, completed by a CSO), and a Treatment Needs Assessment (completed by a licensed counselor).

Applicant Signature _____ Date _____

Defense Attorney Signature _____ Date _____