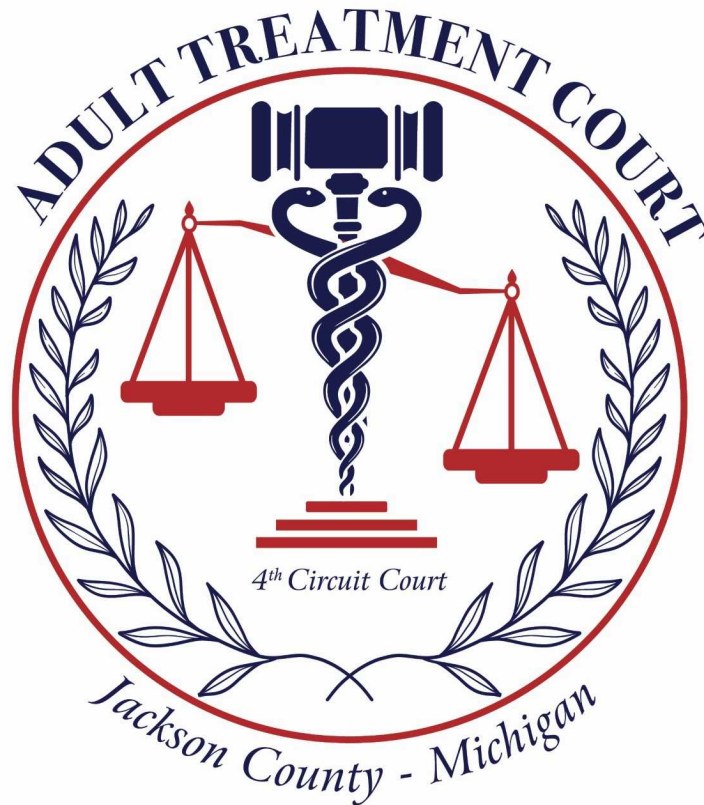


Applicant's Name: _____ Date Received: _____



Hon. Susan B. Jordan

ELIGIBILITY SCREENING FORM

All areas which are marked with an (*)
MUST be filled out completely
If the form is not completed in its entirety,
it will **NOT** be accepted.

STATE OF MICHIGAN COUNTY OF JACKSON 4TH JUDICIAL CIRCUIT	JACKSON COUNTY ADULT TREATMENT COURT ELIGIBILITY SCREENING	Court Case No.
		Judge

PEOPLE OF THE STATE OF MICHIGAN

v

Defendant Name *
Defense Counsel *

Confidentiality Information

The information contained in this application will be used for consideration by the Adult Treatment Court and will be kept confidential and only used for that purpose. By completing this form and submitting it for review, you are giving permission for the Jackson County Adult Treatment Court Team to discuss your information.

Address: *	DOB: *	Age: *	Social Security Number: * XXX-XX-
	Primary Phone *	Alternate Phone	

* Candidate is: Incarcerated On bond

* Charge leading to Treatment Court Referral: _____ *Offense Date _____

* Has Participant been on probation before? Yes No Successfully completed? Yes No

If yes, where? _____

* New criminal offense? Yes No

* Referred by? Self Attorney Probation/Parole Court/Judicial Other

*Currently on probation in another state or county? Yes No If yes, please describe what and where: _____

(Required information, not used for disqualification)

*** RACIAL/ETHNIC BACKGROUND:**

Select all that apply:

<input type="checkbox"/> African-American	<input type="checkbox"/> Hispanic
<input type="checkbox"/> Caucasian	<input type="checkbox"/> Native-American
<input type="checkbox"/> Asian	<input type="checkbox"/> Pacific Islander
<input type="checkbox"/> Multiracial	<input type="checkbox"/> Other

***IDENTIFY GENDER AS:**

Select all that apply:

<input type="checkbox"/> Male
<input type="checkbox"/> Female
<input type="checkbox"/> Non-Binary/Non-Conforming
<input type="checkbox"/> Transgender

***MARITAL STATUS:**

<input type="checkbox"/> Single	<input type="checkbox"/> Separated
<input type="checkbox"/> Married	<input type="checkbox"/> Widowed
	<input type="checkbox"/> Divorced

***EDUCATIONAL STATUS**

<input type="checkbox"/> No high school diploma or GED	<input type="checkbox"/> Associate Degree
<input type="checkbox"/> High school diploma	<input type="checkbox"/> Bachelor Degree
<input type="checkbox"/> GED	<input type="checkbox"/> Advanced Degree
<input type="checkbox"/> Some college	

***EMPLOYMENT STATUS**

<input type="checkbox"/> Unemployed	<input type="checkbox"/> Not in labor Force
<input type="checkbox"/> Employed Full	<input type="checkbox"/> Employed Part Time

***RESIDENCE**

Number of times moved in the last three (3) years _____

Length of time at current address _____

Living Situation Independent Dependent Homeless

***Are you now or were you currently a member of the Armed Forces?** Yes No

If yes, Branch: _____ Dates: _____

*Military Discharge Reason: _____

OFFENSE HISTORY:

* **Felony Convictions:** Yes *If yes, describe below No

Charge type	Location of Arrest	Year

* **Misdemeanor Convictions:** Yes *If yes, describe below No

Charge Type	Location of Arrest	Year

* Have you been **convicted of criminal sexual conduct?** Yes No

* Are you now charged with (or in the past convicted of) a **violent crime?** Yes No

If yes, describe: _____

* Active cases in other jurisdictions? Yes No

If yes, describe: _____

* Are you currently on probation in another state or county? Yes No

If yes, describe: _____

* Are you now charged with (or in the past convicted of) **domestic violence?** Yes No

If yes, describe: _____

* Are you now charged with **OUIL during which someone died or suffered serious bodily injury?** Yes No

If yes, describe: _____

* Did you have **or possess a weapon** or have a weapon in your control **at the time of your arrest?** Yes No

If yes, please describe: _____

* Have you previously been a participant of the Jackson County Adult Treatment Court? Yes No

If you yes, did you successfully complete? Yes No

MEDICAL

* Do you currently have medical insurance: Yes No

If yes, describe: _____

* Do you have any current medical conditions: Yes No

If yes, describe: _____

* Are you currently prescribed Medication for Addiction Treatment (Methadone, Suboxone, Vivitrol) Yes No
 If yes, describe _____

*Have you ever been prescribed Medication Assisted Treatment in the past Yes No
 If yes, please describe _____

* Are you on medications for a medical condition(s)? Yes No
 If yes, describe: _____

*Do you have any type of physical limitations? Yes No If yes, what? _____
 If yes, are you able to participate in our program with this limitation(s)? Yes No

* Have you ever been diagnosed with or treated for a serious mental health disorder? Yes No
 If yes, describe: _____

* Are you taking medication for this? Yes No
 If yes, describe: _____

* What is your primary drug of choice? _____ *Secondary drug of choice ? _____

* Have you ever used IV drugs? Yes No

* Do you currently use IV drugs? Yes No

***Please indicate below the substance you have used and or still using.**

	<u>YES</u>	<u>NO</u>	<u>AGE AT FIRST USE</u>	<u>DATE OF LAST USE</u>	<u>FREQUENCY/AMOUNT USED</u>
ALCOHOL					
COCAINE					
AMPHETAMINES					
METHAMPHETAMINES					
DESIGNER DRUGS					
HALLUCINOGENS					
HEROIN					
INHALANTS					
MARIJUANA					
OTHER OPIATE					
BARBITUATES					
BENZODIAZEPINES					
CODEINE					
TRANQUILIZERS					
STEROIDS					
NICOTINE (Tobacco)					

MOTIVATION TO CHANGE

Do you acknowledge that you abuse or are dependent on drugs or alcohol? Yes No

Are you willing to follow through on an intensive program, which includes substance abuse treatment, drug testing, regular reports to a probation agent, treatment court sessions, education and employment?

Yes No

***FOSTER CARE**

Were you ever placed in a foster home while you were under the age of 18? Yes No

***TRANSPORTATION**

Do you have access to transportation for Treatment Court sessions, treatment and drug tests? Yes No

Please describe: _____

Do you have a valid driver's license? Yes No Driver's License Number _____

**If you have any questions about this form, please call the Treatment Court office at
517-768-7839**

**You may submit the application in person, through your attorney, via mail,
fax or email.**

Jackson County Adult Treatment Court
312 S. Jackson
Jackson, MI 49201

Fax: 517.788.4965

Email: jstressman@mijackson.org

*Defendant's Signature: _____

Defense Counsel Signature: _____

Approved, Assistant Prosecutor: _____

Denied, Assistant Prosecutor: _____

Reason: _____

Substance Use History

Have you ever felt you should cut down on your drinking? Y N

Have people annoyed you by criticizing your drinking? Y N

Have you ever felt bad or guilty about your drinking? Y N

Have you had an eye opener first thing in the morning to steady your nerves or get rid of a hangover?
 Y N

Has a physician ever discussed your drinking or drug use with you? Y N

Have you ever discontinued use of alcohol or other drugs? Y N

If yes, for how long? _____

Why? _____

Have you ever been involved in substance abuse treatment? Y N

If yes, please list place(s) and approximate dates of treatment.

Do you feel you benefited from previous substance abuse treatment? Y N

Please explain: _____

Have you ever attended AA/NA, Self-Help, Mutual Aid or Al-Anon meetings? Y N

Are you attending currently? Y N

Do you have a sponsor/mentor? Y N

Sponsor/Mentor first name _____

When was the last time you used alcohol? _____ How much? _____

When was the last time you used drugs? _____

What kind of drug(s) and how much did you use? _____

Jackson County Adult Treatment Court Drug Abuse Screening Test (DAST-10)

General Instructions

"Drug use" refers to (1) the use of prescribed or over the counter drugs in excess of the directions, and (2) any nonmedical use of drugs.

The various classes of drugs may include cannabis (marijuana, hashish), solvents (e.g., paint thinner), tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., heroin). The questions do not include alcoholic beverages.

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

Name: _____

Date of Assessment: _____

These questions refer to drug use in the past 12 months. Please answer No or Yes.

1. Have you used drugs other than those required for medical reasons?

No Yes

2. Do you use more than one drug at a time?

No Yes

3. Are you always able to stop using drugs when you want to?

No Yes

4. Have you had "blackouts" or "flashbacks" as a result of drug use?

No Yes

5. Do you ever feel bad or guilty about your drug use?

No Yes

6. Does your spouse (or parents) ever complain about your involvement with drugs?

No Yes

7. Have you neglected your family because of your use of drugs?

No Yes

8. Have you engaged in illegal activities in order to obtain drugs?

No Yes

9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?

No Yes

10. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?

No Yes

Comments:

Scoring

Score 1 point for each question answered “Yes,” except for question 3 for which a “No” receives 1 point.

DAST Score: _____