DISTRICT COURT OF MARYLAND

District Eleven

100 W. Patrick St.
Frederick, MD 21701

36 W. Antietam St.
Hagerstown, MD 21740

VETERANS TREATMENT COURT (VTC) REFERRAL FORM

Applicant Information

Full Name:______________________________ Date:______________
Last First M.I.

Address:____
Street Apartment #

____
City State Zip Code

Phone: ______________________ E-Mail:______________________

Military Branch:____________________ Discharge Status:____________________

Health History

Current/Previous Mental Health Diagnosis:______________________________

Current/Previous Substance Abuse Diagnosis:______________________________

Have you ever been treated or hospitalized for mental health reasons? ☐ Yes ☐ No

If you answered yes, please provide dates:______________________________

Have you ever been treated or hospitalized for substance use reasons? ☐ Yes ☐ No

If you answered yes, please provide dates: ______________________________

Case Information

Please list active case number(s) and charge(s) below:

Case Number: ________________ Charges: ______________________________

____

Attorney:____________________ ______________________________

Case Number: ____________________________ Charges: ____

____

Attorney: ________________________________ ____

Case Number: ____________________________ Charges: ____

____

Attorney: ________________________________ ____

Case Number: ____________________________ Charges: ____

____

Attorney: ________________________________ ____

Immediate Needs

Please indicate below what the immediate needs of the Veteran:

Medical	☐ Yes ☐ No	Housing	☐ Yes ☐ No
Mental Health Services	☐ Yes ☐ No	Entitlements	☐ Yes ☐ No
Substance Abuse Services	☐ Yes ☐ No	Employment	☐ Yes ☐ No
Vocational Training	☐ Yes ☐ No	Education	☐ Yes ☐ No

Other: ____

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Significant factors to be aware of (i.e. language barriers, safety concerns, disabilities): ______________________

____

____

Community agency(s) involved: ____

____

Disclaimer and Signature

Referral completed by:____________________________ Agency:________________________

Contact phone number: ___________________________ E-mail:_________________________

I certify that my answers are true and complete to the best of my knowledge.

Signature:_____________________________________ Date:__________________________

Authorization/Consent for Release of Information

I, _______________________________ DOB:__________________ SSN: _____________________ give permission for the Veterans Treatment Court Program team to share information with the State's Attorney's Office, the Office of the Public Defender,____________________________ (Private Legal Counsel), The U.S. Department of Veterans Affairs, and Platoon 22, in order to determine my eligibility in the District Eleven Veterans Treatment Court.

My records obtained and information obtained from this release are to be kept by the District Eleven Veterans Court team and are to be used solely for the purpose of determining eligibility for participation in Veterans Treatment Court.

Any information obtained by this release may NOT be used against me by the State's Attorney or court outside of the Veterans Treatment Court. This information is being shared solely to determine my eligibility into the Veterans Treatment Court program. If I am accepted into the Veterans Treatment Court the records can be used by the Veterans Treatment Court in determining and providing my treatment.

I understand that my records are protected under Federal, State, and HIPAA regulations of confidentiality of protected health care information and cannot be disclosed without my written consent, unless superseded by law. I understand that the information in my health record may include information related to sexually transmitted disease and AIDS/HIV. It may also include information about history, diagnosis and/or treatment of drug or alcohol abuse, mental illness or communicable disease.

I understand that this release is valid when I sign it, and that I can withdraw this release at any time, but that withdrawal of the release may affect my eligibility for Veterans Treatment Court. This authorization will be terminated upon my not being accepted into Veterans Treatment Court, or, if accepted, upon completion of Veterans Treatment Court.

Signature:_____________________________________ Date:______________________
Client or Legal Representative

Signature:_____________________________________ Date:______________________
Witness

Printed Name:__________________________________
Witness

Submission

Submit all pages to the VTC Coordinator via:

E-mail: Julianne.Klappert@mdcourts.gov