

**Drug Treatment Court for Grafton County
Program Application (pg. 1 of 5)**

Date of Application: _____

Name: _____ Alias(es): _____

DOB: _____ Social Security #: _____ Contact Phone #: (____) _____

Email Address: _____ Address: _____

City: _____ State: _____ Zip Code: _____

How long at this address? _____ Cohabitant(s): _____

Relationship(s): _____

Previous Address: _____

Next of kin: _____ Relationship: _____

Address: _____ Phone: (____) _____

Best method and time to contact you: _____

Primary Referral Source: _____ Name of Referral: _____

Demographics:

Sex: _____ Race: _____ Ethnicity: _____

Preferred Language: _____ Citizen Status: _____

Height: _____ Weight: _____ Eye Color: _____ Hair Color: _____

Distinguishing Mark(s)? _____ Location(s): _____

Veteran's Information:

Have you ever served in the military? ☐ Yes ☐ No

Have you ever served in combat? ☐ Yes ☐ No

If yes, are you affiliated with any Veteran Services? ☐ Yes ☐ No

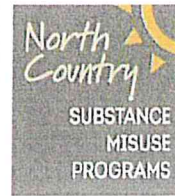
Criminal Justice Information:

Do you have any prior convictions? ☐ Yes ☐ No

DATE	CHARGES	COURT



North Country
HEALTH CONSORTIUM



**Drug Treatment Court for Grafton County
Program Application (pg. 2 of 5)**

Do you have a juvenile record? ☐ Yes ☐ No

Current Charges: _____

Indictment # _____ Stage in Court Process: _____

Next Court Event: _____ Date: _____ Judge: _____

Date of Arrest: _____ Location of Arrest: _____

Pending charges other than those listed above? ☐ Yes ☐ No

If yes, explain: _____

NOTE: Please list ALL current pending charges, including those in other states and counties. Failure to do so may result in your application being denied.

Attorney for current charges: _____ Phone: _____

Attorney for pending charges: _____ Phone: _____

Are you currently on probation or parole? ☐ Yes ☐ No

If yes, name of your PPO: _____ Phone: _____

Have you ever been convicted of a violent crime? ☐ Yes ☐ No

Are you currently incarcerated? ☐ Yes ☐ No If yes, date of incarceration: _____

Do you have any Detainers? ☐ Yes ☐ No Jurisdiction: _____

Health & Substance Abuse History

I have a problem with: ☐ Drugs ☐ Alcohol ☐ Both drugs and alcohol Are you an IV user? ☐ Yes ☐ No

Age of first Use: _____ What did you use? _____ Method of use: _____

First drug of choice: _____ Age of use: _____

Method of use: _____ Date of last use: _____

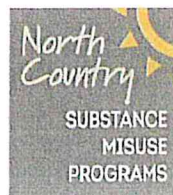
Second drug of choice: _____ Age of use: _____

Method of use: _____ Date of last use: _____

Third drug of choice: _____ Age of use: _____

Method of use: _____ Date of last use: _____

Have you ever been treated for a substance abuse problem? ☐ Yes ☐ No



**Drug Treatment Court for Grafton County
Program Application (pg. 3 of 5)**

Number of previous substance abuse admissions? _____ Inpatient _____ Outpatient

Number of previous mental health admissions? _____ Inpatient _____ Outpatient

If there has been a diagnosis, please describe here: _____

Have you ever been tested for HIV? ☐ Yes ☐ No Do you know the results? ☐ Yes ☐ No

Do you have any current serious medical problems? ☐ Yes ☐ No

Please describe here: _____

What, if anything, have you been diagnosed with? _____

Are you currently on any prescription medications? ☐ Yes ☐ No

Please list here: _____

Personal Information:

Highest level of education completed? _____ Post-secondary schooling? ☐ Yes ☐ No

Do you have a GED? ☐ Yes ☐ No Are you interested in getting your GED? ☐ Yes ☐ No

Do you have a driver's license? ☐ Yes ☐ No Are there any restrictions? ☐ Yes ☐ No

Please explain: _____

Do you have a vehicle or access to a vehicle? ☐ Yes ☐ No

Will transportation be an issue for you? ☐ Yes ☐ No

Do you have any special needs? If yes, please describe: _____

Financial and Employment Information:

Monthly income: _____ Source of income: _____

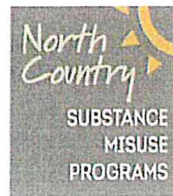
Are you currently employed? ☐ Yes ☐ No Where? _____

Is your current income sufficient to meet your bills? ☐ Yes ☐ No

Do you have Health Insurance? ☐ Yes ☐ No Name of Insurance carrier _____



North Country
HEALTH CONSORTIUM



**Drug Treatment Court for Grafton County
Program Application (pg. 4 of 5)**

Child Care Needs:

Do you have any children? ☐ Yes ☐ No If yes, what are the names and ages: _____

Do you currently have custody of these children? ☐ Yes ☐ No

Are you in immediate need of any of the following services?

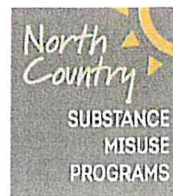
- | | | |
|--|--|--|
| • Housing: <input type="checkbox"/> Yes <input type="checkbox"/> No | • Food: <input type="checkbox"/> Yes <input type="checkbox"/> No | • Pregnancy Care: <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • Medical Care/Insurance:
<input type="checkbox"/> Yes <input type="checkbox"/> No | • Dental Care:
<input type="checkbox"/> Yes <input type="checkbox"/> No | • DMV Information:
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| • Domestic Violence Info:
<input type="checkbox"/> Yes <input type="checkbox"/> No | • Educational Assistance:
<input type="checkbox"/> Yes <input type="checkbox"/> No | • Health and Nutrition:
<input type="checkbox"/> Yes <input type="checkbox"/> No |

In your own words, explain briefly why you would like to enter into the Drug Treatment Court Program and what you hope to gain from it: _____

What do you like to do in your free time? _____



North Country
HEALTH CONSORTIUM



**Drug Treatment Court for Grafton County
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Please Read Carefully

I understand it is my responsibility to return any calls received by the Therapist attempting to schedule an appointment. Failure to schedule or appear for this appointment could result in my application for the Drug Treatment Court being denied. I am aware that the Therapist will make a decision as to the level of care that is needed.

SIGNATURE OF DEFENDANT: _____ Date: _____

This application will not be considered for admission into Drug Treatment Court unless the following certification has been completed. I hereby certify that I have fully explained the Drug Treatment Court program and that I have reviewed with my client the contents of the Drug Treatment Court Participant Handbook and Participation Agreement.

Defense Counsel Signature: _____ Date: _____

By signing this I acknowledge and agree to follow everything in the Drug Treatment Court Handbook. If I have any questions, I will contact the Drug Treatment Court Team.

Signature Date

Defense Counsel Date



CONSENT FOR THE RELEASES OF CONFIDENTIAL TREATMENT INFORMATION

Participant Date of Birth: ____/____/____
MM DD YYYY

I, _____ do hereby consent and authorize any and all of the team members
(Printed Name of Participant)
of the **Drug Treatment Court Sentencing Program for Grafton County** to have reciprocal verbal communication and to exchange written records with:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Robert Akesson (Coordinator), Drug Treatment Court of Grafton County | <input type="checkbox"/> Monica Gasey (Public Defender), NH Public Defenders | <input type="checkbox"/> Marcie Hornick (County Attorney) | <input type="checkbox"/> Stacie Leclerc Blue Heron Neurofeedback and Counseling, LLC |
| <input type="checkbox"/> Alicia Bolyard (Case Manager), Drug treatment Court of Grafton County | <input type="checkbox"/> Amanda Perry (Probation Officer), Drug Treatment Court of Grafton County | <input type="checkbox"/> Lydia McKenzie, DNP | <input type="checkbox"/> Susan Bailey/ Blue Heron Neurofeedback and Counseling, LLC |
| <input type="checkbox"/> Shawn Cannizzaro (Case Manager), Drug Treatment Court of Grafton County | <input type="checkbox"/> Lawrence MacLeod (Judge), Grafton County Superior Court | <input type="checkbox"/> Paul Smith (Chief of Police), Littleton Police Department | <input type="checkbox"/> Gary Richard/ Blue Heron Neurofeedback and Counseling, LLC |
| | <input type="checkbox"/> Viktoriya Kovalenko (Clerk of Courts), Grafton County Superior Court | <input type="checkbox"/> Bob Thompson (Program Director), NCHC | <input type="checkbox"/> Rhonda Bishop/Blue Heron Neurofeedback and Counseling, LLC |
| | | <input type="checkbox"/> Other _____ | |

I DO GIVE CONSENT
(Initial line)

I DO GIVE CONSENT
(Initial line)

- | | |
|--|---|
| 1. Addiction Severity Index (ASI) Assessment _____ | 10. Psychiatric or Psychological Progress Reports _____ |
| 2. Bio-Psycho-Social Assessment _____ | 11. Summary Diagnosis _____ |
| 3. Current Medications _____ | 12. Current Symptoms and Treatment Plan _____ |
| 4. Result of Psychological Evaluation(s) _____ | 13. Statement of Treatment Prognosis _____ |
| 5. Discharge Summary _____ | 14. Statement of Treatment Status/Progress _____ |
| 6. Medical and Physical Examination Results _____ | 15. Results of Drug Testing (including but not limited to, urine, saliva, breath, and perspiration) _____ |
| 7. Other Medical Results _____ | 16. Employment _____ |
| 8. Admissions/Intake Summary _____ | 17. _____ |
| 9. Program Attendance (session, type, frequency) _____ | |

I UNDERSTAND
(Initial line)

1. The purpose or need for such disclosure authorized herein is to comply with the conditions of court orders, assist with assessment and appropriate referral, and/or to keep the Court informed of my status in treatment.
2. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent will remain in force for one (1) year.
3. I understand that my continued participation in the Grafton County Drug Court sentencing Program is conditioned upon ongoing communication between the court and my treatment provider.
4. I understand that I will be asked to renew this consent, at a minimum, on an annual basis, throughout the course of my participating in the Grafton County Drug Court Sentencing Program.
5. I understand that my records are protected under the federal regulations governing confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for in the Code of Federal Regulations.

Participant's Signature _____

Date _____

Signature of Witness _____

Date _____

Name & Title of Witness (PRINTED) _____



CONSENT FOR THE RELEASES OF CONFIDENTIAL TREATMENT INFORMATION

Participant Date of Birth: ____/____/____
MM DD YYYY

I, _____ do hereby consent and authorize any and all of the team members
(Printed Name of Participant)
of the **Drug Treatment Court Sentencing Program for Grafton County** to have reciprocal verbal communication and to exchange written records with:

- | | |
|---|---|
| <input type="checkbox"/> Tara Heater (County Attorney) | <input type="checkbox"/> Renee Sargent (Public Defender), NH Public Defenders |
| <input type="checkbox"/> James Simpson (County Attorney) | <input type="checkbox"/> Jennifer Szafir (Public Defender), NH Public Defenders |
| <input type="checkbox"/> Jason Novak (Public Defender), NH Public Defenders | |

I **DO** GIVE CONSENT
(Initial line)

I **DO** GIVE CONSENT
(Initial line)

- | | | | |
|--|-------|---|-------|
| 1. Addiction Severity Index (ASI) Assessment | _____ | 10. Psychiatric or Psychological Progress Reports | _____ |
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| 8. Admissions/Intake Summary | _____ | 17. _____ | _____ |
| 9. Program Attendance (session, type, frequency) | _____ | | |

I UNDERSTAND
(Initial line)

1. The purpose or need for such disclosure authorized herein is to comply with the conditions of court orders, assist with assessment and appropriate referral, and/or to keep the Court informed of my status in treatment.
2. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent will remain in force for one (1) year.
3. I understand that my continued participation in the Grafton County Drug Court sentencing Program is conditioned upon ongoing communication between the court and my treatment provider.
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Participant's Signature

Date

Signature of Witness

Date

Name & Title of Witness (PRINTED)



CONSENT FOR THE RELEASE OF CONFIDENTIAL TREATMENT INFORMATION

Participant Date of Birth: ____/____/____
MM DD YYYY

I, _____ do hereby consent and authorize any and all of the team members
(Printed Name of Participant)
of the **Drug Treatment Court Sentencing Program for Grafton County to include Blue Heron Neurofeedback and Counseling which is the clinical treatment provider for DTC**, to have reciprocal verbal communication and to exchange written records with:

☒ Other: Attorney -

I DO GIVE CONSENT
(Initial line)

(Please write your attorney's name)
I DO GIVE CONSENT
(Initial line)

- | | | | |
|--|-------|---|-------|
| 1. Addiction Severity Index (ASI) Assessment | _____ | 10. Psychiatric or Psychological Progress Reports | _____ |
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| 9. Program Attendance (session, type, frequency) | _____ | | |

I UNDERSTAND

1. The purpose or need for such disclosure authorized herein is to comply with the conditions of court orders, assist with assessment and appropriate referral, and/or to keep the Court informed of my status in treatment. (Initial line) _____
2. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent will remain in force until the day I graduate from Drug Treatment Court Sentencing Program or the day I am terminated from the Drug Treatment Court Sentencing Program. Revoking this consent may lead to sanctions imposed by the Drug Treatment Court Sentencing Program team up to, and possibly including termination from the program _____
3. I understand that my continued participation in the Grafton County Drug Treatment Court sentencing Program is conditioned upon ongoing communication between the court and my treatment provider. _____
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Participant's Signature

Date

Signature of Witness

Date



CONSENT FOR THE RELEASE OF CONFIDENTIAL TREATMENT INFORMATION

Participant Date of Birth: ____/____/____
MM DD YYYY

I, _____ do hereby consent and authorize any and all of the team members
(Printed Name of Participant)
of the **Drug Treatment Court Sentencing Program for Grafton County to include Blue Heron Neurofeedback and Counseling which is the clinical treatment provider for DTC**, to have reciprocal verbal communication and to exchange written records with:

☒ Other: Grafton County HAC

I DO GIVE CONSENT
(Initial line)

I DO GIVE CONSENT
(Initial line)

- | | | | |
|--|-------|---|-------|
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I UNDERSTAND

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Participant's Signature

Date

Signature of Witness

Date



CONSENT FOR THE RELEASE OF CONFIDENTIAL TREATMENT INFORMATION

Participant Date of Birth: ____/____/____
MM DD YYYY

I, _____ do hereby consent and authorize any and all of the team members
(Printed Name of Participant)
of the **Drug Treatment Court Sentencing Program for Grafton County to include Blue Heron Neurofeedback and Counseling which is the clinical treatment provider for DTC**, to have reciprocal verbal communication and to exchange written records with:

☒ Other: NH Detox

I **DO** GIVE CONSENT
(Initial line)

I **DO** GIVE CONSENT
(Initial line)

- | | | | |
|--|-------|---|-------|
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Participant's Signature

Date

Signature of Witness

Date



CONSENT FOR THE RELEASE OF CONFIDENTIAL TREATMENT INFORMATION

Participant Date of Birth: ____/____/____
MM DD YYYY

I, _____ do hereby consent and authorize any and all of the team members
(Printed Name of Participant)
of the **Drug Treatment Court Sentencing Program for Grafton County to include Blue Heron Neurofeedback and Counseling which is the clinical treatment provider for DTC**, to have reciprocal verbal communication and to exchange written records with:

☒ Other: Avenues

I **DO** GIVE CONSENT
(Initial line)

I **DO** GIVE CONSENT
(Initial line)

- | | | | |
|--|-------|---|-------|
| 1. Addiction Severity Index (ASI) Assessment | _____ | 10. Psychiatric or Psychological Progress Reports | _____ |
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Participant's Signature

Date

Signature of Witness

Date



CONSENT FOR THE RELEASE OF CONFIDENTIAL TREATMENT INFORMATION

Participant Date of Birth: ____/____/____
MM DD YYYY

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(Printed Name of Participant)
of the **Drug Treatment Court Sentencing Program for Grafton County to include Blue Heron Neurofeedback and Counseling which is the clinical treatment provider for DTC**, to have reciprocal verbal communication and to exchange written records with:

☒ Other: Live Free

I DO GIVE CONSENT
(Initial line)

I DO GIVE CONSENT
(Initial line)

- | | | | |
|--|-------|---|-------|
| 1. Addiction Severity Index (ASI) Assessment | _____ | 10. Psychiatric or Psychological Progress Reports | _____ |
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Participant's Signature

Date

Signature of Witness

Date



CONSENT FOR THE RELEASE OF CONFIDENTIAL TREATMENT INFORMATION

Participant Date of Birth: ____/____/____
MM DD YYYY

I, _____ do hereby consent and authorize any and all of the team members
(Printed Name of Participant)
of the **Drug Treatment Court Sentencing Program for Grafton County to include Blue Heron Neurofeedback and Counseling which is the clinical treatment provider for DTC**, to have reciprocal verbal communication and to exchange written records with:

☒ Other: White Mountains Recovery Home

I **DO** GIVE CONSENT
(Initial line)

I **DO** GIVE CONSENT
(Initial line)

- | | | | |
|--|-------|---|-------|
| 1. Addiction Severity Index (ASI) Assessment | _____ | 10. Psychiatric or Psychological Progress Reports | _____ |
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| 8. Admissions/Intake Summary | _____ | 17. _____ | _____ |
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- The purpose or need for such disclosure authorized herein is to comply with the conditions of court orders, assist with assessment and appropriate referral, and/or to keep the Court informed of my status in treatment.
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Participant's Signature

Date

Signature of Witness

Date



CONSENT FOR THE RELEASE OF CONFIDENTIAL TREATMENT INFORMATION

Participant Date of Birth: ____/____/____
MM DD YYYY

I, _____ do hereby consent and authorize any and all of the team members
(Printed Name of Participant)
of the **Drug Treatment Court Sentencing Program for Grafton County to include Blue Heron Neurofeedback and Counseling which is the clinical treatment provider for DTC**, to have reciprocal verbal communication and to exchange written records with:

☒ Other: Saving Grace

I **DO** GIVE CONSENT
(Initial line)

I **DO** GIVE CONSENT
(Initial line)

- | | | | |
|--|-------|---|-------|
| 1. Addiction Severity Index (ASI) Assessment | _____ | 10. Psychiatric or Psychological Progress Reports | _____ |
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I **UNDERSTAND**
(Initial line)

- The purpose or need for such disclosure authorized herein is to comply with the conditions of court orders, assist with assessment and appropriate referral, and/or to keep the Court informed of my status in treatment.
- I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent will remain in force until the day I graduate from Drug Treatment Court Sentencing Program or the day I am terminated from the Drug Treatment Court Sentencing Program. Revoking this consent may lead to sanctions imposed by the Drug Treatment Court Sentencing Program team up to, and possibly including termination from the program
- I understand that my continued participation in the Grafton County Drug Treatment Court sentencing Program is conditioned upon ongoing communication between the court and my treatment provider.
- I understand that my records are protected under the federal regulations governing confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for in the Code of Federal Regulations.

Participant's Signature _____

Date _____

Signature of Witness _____

Date _____



CONSENT FOR THE RELEASE OF CONFIDENTIAL TREATMENT INFORMATION

Participant Date of Birth: ____/____/____
MM DD YYYY

I, _____ do hereby consent and authorize any and all of the team members
(Printed Name of Participant)
of the **Drug Treatment Court Sentencing Program for Grafton County to include Blue Heron Neurofeedback and Counseling which is the clinical treatment provider for DTC**, to have reciprocal verbal communication and to exchange written records with:

☒ Other: Head rest

I DO GIVE CONSENT
(Initial line)

I DO GIVE CONSENT
(Initial line)

- | | | | |
|--|-------|---|-------|
| 1. Addiction Severity Index (ASI) Assessment | _____ | 10. Psychiatric or Psychological Progress Reports | _____ |
| 2. Bio-Psycho-Social Assessment | _____ | 11. Summary Diagnosis | _____ |
| 3. Current Medications | _____ | 12. Current Symptoms and Treatment Plan | _____ |
| 4. Result of Psychological Evaluation(s) | _____ | 13. Statement of Treatment Prognosis | _____ |
| 5. Discharge Summary | _____ | 14. Statement of Treatment Status/Progress | _____ |
| 6. Medical and Physical Examination Results | _____ | 15. Results of Drug Testing (including but not limited to, urine, saliva, breath, and perspiration) | _____ |
| 7. Other Medical Results | _____ | 16. Employment | _____ |
| 8. Admissions/Intake Summary | _____ | 17. _____ | _____ |
| 9. Program Attendance (session, type, frequency) | _____ | | |

I UNDERSTAND
(Initial line)

- The purpose or need for such disclosure authorized herein is to comply with the conditions of court orders, assist with assessment and appropriate referral, and/or to keep the Court informed of my status in treatment.
- I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent will remain in force until the day I graduate from Drug Treatment Court Sentencing Program or the day I am terminated from the Drug Treatment Court Sentencing Program. Revoking this consent may lead to sanctions imposed by the Drug Treatment Court Sentencing Program team up to, and possibly including termination from the program
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Participant's Signature

Date

Signature of Witness

Date