



## SUPERIOR COURT OF COBB COUNTY VETERANS ACCOUNTABILITY AND TREATMENT COURT

### APPLICATION INSTRUCTIONS

1. Review with the defendant the program eligibility requirements (please see Judicial Council of Georgia's "Standard for Accountability Courts §2.3" concerning defense counsel). In order to participate in this program, the defendant must:
  - a. Be a veteran of the United States armed forces and have been discharged under honorable conditions.
  - b. Face an issue of mental illness, post traumatic stress disorder, or substance abuse.
  - c. Be competent to enter a plea of guilty.
  - d. Have, or be able to obtain, stable housing in Cobb County.
2. Complete and sign all documents included in this packet. If the case has been indicted or accused, ***you must include the Indictment/Accusation number on each applicable document.*** If the case has not been indicted or accused, you must include the warrant number. Do not include any other identifying numbers, such as the police complaint number.
3. File the "PETITION TO PARTICIPATE IN VETERANS ACCOUNTABILITY AND TREATMENT COURT" form with the Clerk of Superior Court, if the case has been indicted or accused. If there is no indictment or accusation, the petition may remain with this packet.
4. Return all remaining documents to District Attorney's Director of Accountability Courts for further review.
5. Upon notification of defendant's acceptance into the program, arrange to schedule defendant's plea submission.
  - a. Those defendants eligible to participate on a pre-adjudication basis (who have no prior felony convictions) will plead guilty but sentence will be withheld. Upon successful graduation the plea will be withdrawn and a Nolle Prosequi order entered.
  - b. Those defendants with prior felony convictions will plead guilty and be sentenced, with participation in this program made a special condition.

*After thoroughly reading these instructions, if you have any questions please call the District Attorney's Director of Accountability Courts at 770-528-3080. The enclosed documents may be amended or supplemented at any time in the discretion of the Veterans Court team, therefore a new packet must be obtained by visiting [www.cobbda.com](http://www.cobbda.com) for each defendant. **Copies should not be kept for future use.***





Court staff, regardless of whether it is legal to possess or use such substance. I will not associate with people who use or possess such substances, nor will I knowingly be present while drugs, alcohol, or other such substances are being used by others.

9. \_\_\_\_\_ I will submit to testing for the presence of illegal or non-prescribed drugs, alcohol, and perception or mood altering substances in my system on a random basis according to procedures established by the Veterans Court team and/or treatment provider. I understand that I will be given a location and time to report for my drug test. I understand that it is my responsibility to report to the assigned location at the time given.
10. \_\_\_\_\_ I will not substitute, alter or try in any way to change my body fluids for purposes of testing.
11. \_\_\_\_\_ I will submit to a drug or alcohol test at any time, by any police officer, treatment provider, Veterans Court staff member, or at the direction of the Court or any agency designated by the Court.
12. \_\_\_\_\_ I will avoid persons and places of disreputable or harmful character or knowingly associating with persons who violate the law.
13. \_\_\_\_\_ I will not violate the laws of any governmental unit during my participation in this program.
14. \_\_\_\_\_ I will inform any law enforcement officer with whom I come in contact that I am a participant in Veterans Court and will immediately report to Veterans Court if I am arrested or issued a citation for any criminal offense by any law enforcement agency.
15. \_\_\_\_\_ I will not possess any weapons while I am in Veterans Court. I will dispose of any and all weapons in my possession, and disclose the presence of any weapons possessed by anyone else in my household.
16. \_\_\_\_\_ I will maintain a stable residence within Cobb County at all times during my participation in this program. I will keep the Veterans Court team advised of my current address, telephone number, and employment or school status, and will immediately report any change in status.
17. \_\_\_\_\_ I will not leave the State of Georgia at any time, or stay overnight at a location other than my approved residence, during the course of the program without the prior permission of the Veterans Court staff.
18. \_\_\_\_\_ I agree that if, in the reasonable opinion of a member of the Veterans Court team or a treatment provider, I exhibit behaviors indicating a risk of harm to myself or others, the proper authorities and my next of kin may be notified of such behavior. I hereby waive any right of confidentiality I may have in such information under such circumstances.
19. \_\_\_\_\_ I understand that any right I may have to request that my criminal history record be restricted (what is commonly known as “expungement”) will be governed solely by O.C.G.A. §35-3-37, and that any request for such restriction must be filed in a separate proceeding. Nothing in this agreement shall guarantee any restriction on my criminal record, or limit my right to seek such restriction as allowed by law.
20. \_\_\_\_\_ I understand that this agreement is subject to future revisions, additions, and/or amendments, and that should my consent to such revision, addition, or amendment be required during my participation in this program, I will have the right to seek the advice of counsel.

I have read the above contract, or had it read to me, and I acknowledge that I understand all of its terms and conditions. **I understand that failure to comply with any of the conditions herein may result in a sanction up to and including termination from the program.** I have been given the opportunity to ask any questions which I may have. I hereby voluntarily enter into this agreement with the Cobb County Superior Court Veterans Accountability and Treatment Court Program.

\_\_\_\_\_  
Defendant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Attorney for Defendant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Assistant District Attorney

\_\_\_\_\_  
Date

\_\_\_\_\_  
Veterans Court Judge

\_\_\_\_\_  
Date

**TO BE COMPLETED BY DEFENSE COUNSEL** *(please initial each):*

\_\_\_\_\_ I have explained the above information, along with the other application materials, to the defendant. I have explained the constitutional rights which the defendant hereby waives by submitting these materials.

\_\_\_\_\_ I believe that the defendant understands his/her constitutional rights and the consequences of entering this agreement.

\_\_\_\_\_ I believe (to the best of my professional knowledge and without rendering a medical opinion) that the defendant is competent to enter this agreement and does so freely and voluntarily.



SUPERIOR COURT OF COBB COUNTY  
VETERANS ACCOUNTABILITY AND TREATMENT COURT  
**PROGRAM PARTICIPANT INFORMATION**

**Personal Information**

Case Number \_\_\_\_\_ Date \_\_\_\_\_

Name \_\_\_\_\_ D.O.B. \_\_\_\_\_

Address \_\_\_\_\_  
Street Apt# City State ZIP

County of Residence \_\_\_\_\_

Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_

Marital Status \_\_\_\_\_

Children (number and ages) \_\_\_\_\_

Contact in case of Emergency \_\_\_\_\_  
Name Relationship

Telephone (Home) (\_\_\_\_) \_\_\_\_\_ (Other) (\_\_\_\_) \_\_\_\_\_

**Employment**

Employer \_\_\_\_\_

Address \_\_\_\_\_  
Street Apt# City State ZIP

Telephone (\_\_\_\_) \_\_\_\_\_ Immediate Supervisor \_\_\_\_\_

**Medical Coverage Information**

Medicare       Medicaid       medication assistance (provide detail below)

Insurance \_\_\_\_\_

Other \_\_\_\_\_



SUPERIOR COURT OF COBB COUNTY  
VETERANS ACCOUNTABILITY AND TREATMENT COURT

PROGRAM PARTICIPANT INFORMATION

Service Information

Defendant Name: \_\_\_\_\_ Case No.: \_\_\_\_\_

Branch of Service: \_\_\_\_\_

Years Active Duty: \_\_\_\_\_ From \_\_\_\_\_ to \_\_\_\_\_

Years Reserve: \_\_\_\_\_ From \_\_\_\_\_ to \_\_\_\_\_

Discharge:     Honorable             General             Other than Honorable Conditions  
                   Bad Conduct             Dishonorable             Entry Level Separation

Overseas deployment(s) and dates: \_\_\_\_\_  
\_\_\_\_\_

Combat Experience:  Yes     No

If yes, please give dates and locations: \_\_\_\_\_  
\_\_\_\_\_

Applied for veterans benefits through Department of Veterans Affairs:  Yes     No

If yes, were benefits approved:  Yes             No

Received a Department of Veterans Affairs disability rating:  Yes             No

If yes, percentage of disability: \_\_\_\_\_%



**SUPERIOR COURT OF COBB COUNTY  
VETERANS ACCOUNTABILITY AND TREATMENT COURT  
PROGRAM PARTICIPANT INFORMATION**

**References**

Defendant Name \_\_\_\_\_ Case No. \_\_\_\_\_

*Provide information for at least 2 people who Veterans Court staff may contact to verify the information contained in this application or to seek additional information. If Defendant will live with another person during participation in this program, that person must be included here.*

**Reference #1** \_\_\_\_\_  
Name Relationship

Address \_\_\_\_\_  
Street Apt# City State ZIP

Telephone (\_\_\_\_) \_\_\_\_\_ If defendant lives with this person check here

**Reference #2** \_\_\_\_\_  
Name Relationship

Address \_\_\_\_\_  
Street Apt# City State ZIP

Telephone (\_\_\_\_) \_\_\_\_\_ If defendant lives with this person check here

**Reference #3** \_\_\_\_\_  
Name Relationship

Address \_\_\_\_\_  
Street Apt# City State ZIP

Telephone (\_\_\_\_) \_\_\_\_\_ If defendant lives with this person check here

I hereby give permission for Drug Treatment Court staff members to contact the above individuals. I waive any right of confidentiality which may exist and I consent to these individuals discussing my living arrangements, mental health status, substance abuse, criminal charges, and any other information which may aid in assessing my eligibility for this program.

\_\_\_\_\_  
Defendant's Signature

\_\_\_\_\_  
Date



SUPERIOR COURT OF COBB COUNTY  
VETERANS ACCOUNTABILITY AND TREATMENT COURT

**MEMORANDUM OF UNDERSTANDING CONCERNING ATTORNEY-CLIENT  
RELATIONSHIP IN VETERANS ACCOUNTABILITY AND TREATMENT COURT**

I, \_\_\_\_\_, having requested to participate in the Cobb County Veterans Accountability and Treatment Court Program (“Veterans Court”), understand that decisions concerning the administration of this program are made by a multi-disciplinary team which may include program administrators, treatment providers, probation officers, Veterans Administration or Department of Defense officials, and attorneys representing both prosecution and defense, under the direction of the Veterans Court judge. While attorneys, including prosecutors, take part in this process, the program does not operate under the traditional adversarial model of other court proceedings. Because of this, I understand and agree to the following:

1. Prior to my acceptance into Veterans Court, I have the right to be represented by an attorney, either one chosen and retained by me or one appointed by the Cobb County Circuit Defender’s Office. This attorney can advise me, among other things, as to whether Veterans Court is an appropriate and beneficial alternative to the traditional criminal litigation process in my particular case.
2. After my acceptance into Veterans Court, the administrator of the Cobb County Circuit Defender’s Office, or his designee, will act as the defense representative on the Veterans Court Team. I will no longer have the right to have my previous attorney advise me regarding the decisions made by this team, including the imposition of sanctions where appropriate.
3. During my participation in this program, the defense representative will act not as my attorney in the traditional sense, but as a member of the Veterans Court team. As such, he or she will join in discussions and decisions regarding my participation in the program including, but not limited to, my advancement or non-advancement through the phases of the program and the imposition of sanctions for violations of the program’s rules or contract.
4. The duties of the defense representative as a member of the Veterans Court team may not be in my best interest if I have violated any provision of Veterans Court’s rules or contract.
5. I will not have the right to have an attorney represent me individually at court appearances during my participation in Veterans Court or before the Veterans Court team, even if the Court is considering whether to impose a sanction. Veterans Court proceedings are not “critical stages of litigation” and therefore I do not have a right

to be represented by an attorney during these proceedings. I understand that my case may be discussed, and sanctions (including incarceration) may be imposed, without my attorney or the prosecutor present.

6. Should the Veterans Court team decide to recommend that the Court terminate my participation in the program due to a violation or violations of the program's rules or contract, I will be entitled to be represented by an attorney, either one chosen and retained by me or one appointed by the Cobb County Circuit Defender's Office. This attorney may then represent me individually in termination proceedings and in any subsequent litigation involving the disposition of my case outside Veterans Court.

I have read this document or had it read to me and have been given the opportunity to ask any questions I may have. I have been given the opportunity to discuss this document with my attorney and have sought his or her advice as to whether Veterans Court would be beneficial for me, and I wish to be considered for participation in this program.

This the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_.

\_\_\_\_\_  
Defendant

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Attorney for Defendant

\_\_\_\_\_  
Print Name



SUPERIOR COURT OF COBB COUNTY  
VETERANS ACCOUNTABILITY AND TREATMENT COURT

**CRIMINAL HISTORY CONSENT FORM**

I hereby authorize the Cobb County Veterans Accountability and Treatment Court (“Veterans Court”) and/or Cobb County Sheriff’s Office to receive any criminal history record information pertaining to me which may be in the files of any criminal justice agency of any state, or any local criminal justice agency in the state of Georgia. This authorization shall be effective at any time during my participation in Veterans Court as well as at intervals of one, two, and five years after my completion of the program. I further give consent to the Veterans Court team to view my juvenile criminal history for the purpose of assessment only. I understand that such juvenile records cannot be used against me as an adult.

\_\_\_\_\_  
Full name printed

\_\_\_\_\_  
Address

\_\_\_\_\_  
City State Zip Code

\_\_\_\_\_  
Sex Race DOB Social Security Number

\_\_\_\_\_  
Drivers’ License Number State

\_\_\_\_\_  
Participant’s Signature

IN THE SUPERIOR COURT OF COBB COUNTY  
VETERANS ACCOUNTABILITY AND TREATMENT COURT  
STATE OF GEORGIA

THE STATE OF GEORGIA

§

CASE NO.

V.

§

§

**WAIVER OF RIGHT TO ASSERT SPECIFIED GROUNDS**

**AS A BASIS FOR MOTION OF RECUSAL**

The defendant, and his or her counsel, hereby acknowledge that as consideration for acceptance and/or continued participation in the Cobb County Veterans Accountability and Treatment Court Program (“Veterans Court”):

1. That the above-styled case will be assigned to the Veterans Court division of Superior Court, and a designated elected, senior, or assisting Superior Court judge will sit as the Veterans Court judge;
2. That the Veterans Court judge will preside over any termination hearings, should consideration of termination arise prior to graduation; and
3. That should defendant fail to successfully complete Veterans Court and be terminated from said program, disposition of the case may be decided by the designated Veterans Court judge or may be referred to the previously-assigned judge.

Understanding that the assignment of this case may be to the designated Veterans Court judge throughout all proceedings until ultimate disposition of the case, irrespective of defendant’s success or failure in completing Veterans Court, the defendant hereby waives his or her right to assent, as a basis for a motion to recuse the Veterans Court judge, any of the following:

1. The personal involvement of the Veterans Court judges with the defendant during his or her participation in Veterans Court;
2. The Veterans Court judges’ knowledge, both personal and otherwise, of defendant’s compliance or non-compliance with the requirements of Veterans Court; or
3. The Veterans Court judge’s decision to terminate the defendant from Veterans Court on the basis of his or her failure to comply with such requirements.

Defendant hereby freely, voluntarily and knowingly waives the right to assert the foregoing as grounds for a motion to recuse and acknowledges that he or she does so having consulted with counsel.

This the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_.

\_\_\_\_\_  
Defendant

\_\_\_\_\_  
Attorney for Defendant



IN THE SUPERIOR COURT OF COBB COUNTY  
VETERANS ACCOUNTABILITY AND TREATMENT COURT  
STATE OF GEORGIA

THE STATE OF GEORGIA

§

CASE NO.

V.

§

\_\_\_\_\_

§

**WAIVER OF FOURTH AMENDMENT RIGHTS**

I, \_\_\_\_\_, having requested to participate in the Cobb County Veterans Accountability and Treatment Court Program, and in consideration of the agreement by the State to allow such participation in lieu of traditional prosecution of my charged offense(s), hereby state the following:

I understand that I have rights that protect me from unreasonable search and seizure.

I understand that these rights are guaranteed by the Fourth Amendment to the United States Constitution, as well as the Constitution of the State of Georgia.

I also understand that I can voluntarily give up these rights as part of an agreement to provide an alternative to traditional prosecution or incarceration.

As a condition of my participation in this program, I agree to allow the search of my person, property, place of residence, vehicle or personal effects at any time with or without a warrant, and with or without reasonable cause, when required by a probation officer, treatment staff, Veterans Court staff, and/or any law enforcement officer at any time during my participation in this program. I hereby give permission for such individuals to remove, forcibly if necessary, any locks or other hindrances which may prevent access to such places and property for the purpose of any such search. I consent to the use of any evidence seized during such a search in any prosecution that may arise from said search.

This the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_  
Defendant

\_\_\_\_\_  
Attorney for Defendant



SUPERIOR COURT OF COBB COUNTY  
VETERANS ACCOUNTABILITY AND TREATMENT COURT

DRUG SCREEN POLICY

I understand that if I test positive for drugs or alcohol at the time of my assessment, it will not be held against me because this screen is used to help determine eligibility for the Veterans Accountability and Treatment Court Program. However, I understand and agree that if I use drugs and/or alcohol at any time after the assessment, even prior to my acceptance or orientation into the program, I will receive a sanction which may include jail or termination from the program. I agree to read and abide by the drug screening procedures explained in these materials or by any member of the Veterans Court team.

I understand that if my urine drug screen indicates a positive result for any illegal or non-prescribed drug or alcohol, based on any testing method approved by the Court, at any time while in the program, I will receive a sanction. I understand that the Court will not conduct any evidentiary hearing to allow me to contest such a result and that I will not be allowed to submit any separate results from any other laboratory or testing process. I understand that I will be given the opportunity to request a confirmatory test at my own expense; however I also understand that should *such testing confirm the positive result my sanction will be increased.*

I understand that if I test positive on any alcohol and/or drug test, and the result is obtained while I am present at any court or treatment facility, then I will not be allowed to operate a motor vehicle. I will immediately surrender my automobile keys to staff and call someone for a ride home.

I understand that if I miss, or arrive more than 30 minutes late for, any scheduled drug screen, the test will be presumed to be positive. I understand that any sample which does not contain a sufficient volume of liquid for testing, or which is dilute (that is, which contains a concentration of creatinine less than 20 mg/dl), will be deemed inadequate for testing, and the test will be presumed to be positive. I further understand that, for any such presumed positive test, I will receive a sanction which may include incarceration or termination from the program.

\_\_\_\_\_  
Participant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print name



SUPERIOR COURT OF COBB COUNTY  
VETERANS ACCOUNTABILITY AND TREATMENT COURT

**CONSENT FOR DISCLOSURE OF CONFIDENTIAL INFORMATION**

I, \_\_\_\_\_, hereby consent to communication, within or outside my presence, regarding my medical, psychological, or substance abuse history among any of the following individuals: the Veterans Court judge, any Veterans Administration, Veterans Justice Outreach, or Department of Defense employee whose participation in the administration of this program is deemed necessary by the Veterans Court judge, any physician, psychiatrist, or psychologist designated by the Veterans Court or its treatment providers, any prosecutor designated by the District Attorney, any attorney designated by me or by the Cobb County Circuit Defender's Office, any member of the Veterans Court team, and any evaluator or counselor designated by the Veterans Court treatment providers. I understand and agree that the purpose and need for this disclosure is to assist the Court in evaluating and determining my eligibility to participate in Veterans Court as well as my prognosis, compliance and progress in accordance with Veterans Court criteria. I hereby agree to hold such individuals harmless and relieve and release such individuals from any and all liability regarding any such communication.

This consent extends only to that communication which is necessary for and pertinent to hearings and/or reports concerning my specific Veterans Court case. Recipients of this information may not re-disclose it except in connection with my Veterans Court treatment and then only with my written consent, except as permitted by federal law and rules, including but not limited to bona fide medical emergencies, valid court orders, and when there is a suspicion of a danger to others (including suspicion of child abuse or neglect).

Any information obtained through this release is for the exclusive use of the individuals described above. All documents generated by this release shall be kept separate and apart from court file.

I understand that this consent will remain in effect and cannot be revoked by me until there has been a formal and effective termination of my involvement with the Veterans Accountability and Treatment Court Program, and/or a formal discontinuation of court proceedings regarding my case.

\_\_\_\_\_  
Participant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print name



SUPERIOR COURT OF COBB COUNTY  
VETERANS ACCOUNTABILITY AND TREATMENT COURT

FRATERNIZATION RULES

The following rules apply to participants in any of the Cobb County Accountability Court programs (Drug Treatment Court, Intermediate Drug Treatment Court, Mental Health Court, and Veterans Accountability and Treatment Court). "Participant," as used below, shall apply to any participant in any of said programs.

I, \_\_\_\_\_, having requested to participate in the Cobb County Veterans Accountability and Treatment Court Program ("Veterans Court"), understand and agree to the following:

1. Any sexual involvement with any participant, current or former member of Accountability Court staff or drug lab is prohibited under any circumstances. In addition to physical contact, this includes any communication of a sexual nature by phone, internet, social media, or otherwise. Participants shall not exchange or display sexually explicit photographs amongst themselves or with current or former members of any Accountability Court staff or the drug lab.
2. Romantic relationships with another participant, or current or former member of any Accountability Court staff is prohibited. Contact between participants and current or former staff of a romantic nature, or that is intended to encourage a romantic or "dating" relationship, is not allowed. This includes physical contact as well as any communication by phone, internet, social media, or otherwise.
3. Social contact between participants of a non-romantic, non-sexual nature may, in some cases, be a beneficial part of the recovery process, and is therefore not prohibited. However, any social contact between participants outside of a treatment or court setting must be disclosed to treatment staff at the earliest opportunity. Relationships of any sort that are shown to be harmful to a participant's recovery process may not be compatible with the participant's treatment plan, and will be addressed by the treatment staff and, if necessary, the court.
4. Participants must avoid persons and places of disreputable or harmful character. This includes, but is not limited to, avoiding romantic relationships with convicted felons.
5. Participants may not be employed by the same employer or work together, whether paid or unpaid, without prior approval of the court.
6. Participants may not provide transportation for one another, give or loan each other money or items of value, or perform services for one another without prior approval of the court.

I have read this document or had it read to me and have been given the opportunity to ask any questions I may have. I hereby agree to abide by the above rules as a condition of my participation in the Mental Health Court Program. I understand that any violation of these rules may result in a sanction up to and including termination from the program.

\_\_\_\_\_  
Participant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print name



SUPERIOR COURT OF COBB COUNTY  
VETERANS ACCOUNTABILITY AND TREATMENT COURT

**DISCHARGE POLICY**

I understand that, once I have been accepted into this program, I will remain a participant in this program and be subject to all rules and requirements until I am discharged by the entry of a written order of the Veterans Court judge, my completion of certain phase requirements or participation in exit interviews or graduation ceremonies notwithstanding. I understand that a discharge order will only be entered in the event of: 1) successful completion and graduation from the program, 2) termination from the program by order of the Court, or 3) withdrawal by permission of the Veterans Court judge. I understand that I will not at any time have the option to unilaterally withdraw from the program, even if I am facing a sanction.

I further understand that my graduation from this program will be contingent upon the results of a final urine drug screen which will be administered on the day of my scheduled graduation. I understand that a positive result on this test may lead to a sanction, including termination, or to my return to active treatment.

\_\_\_\_\_  
Participant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print name



Department of Veterans Affairs

**REQUEST FOR AND CONSENT TO RELEASE OF  
MEDICAL RECORDS PROTECTED BY 38 U.S.C. 7332**

**PAPERWORK REDUCTION ACT INFORMATION:** Public reporting burden for this collection of information is estimated to average 2 minutes per response, including the time for reviewing instruction, searching existing data sources, gathering and maintaining the data needed and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden to VA Clearance Officer (723) , 810 Vermont Avenue NW, Washington DC 20420, and to the Office of Information and Regulatory Affairs, Paperwork Reduction Project (2900-0260), Office of Management and Budget, Washington DC 20503. DO NOT send applications to this address.

The execution of this form does not authorize the release of information other than that specifically described below. The information requested on this form is solicited under Title 38, U.S.C. and will authorize release of information you specify. Your disclosure of the information requested on this form is voluntary. However, if the information is not furnished, Department of Veterans Affairs will be unable to comply with the request.

ENTER BELOW THE PATIENT'S NAME AND SOCIAL SECURITY NUMBER IF THE PATIENT DATA CARD IMPRINT IS NOT USED.

TO: Department of Veterans Affairs

PATIENT NAME (Last, First, Middle Initial)

X

SOCIAL SECURITY NUMBER

X

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED.

County Court, Attorney, Public Defender, Probation Officer, Family member and Jail Staff

**VETERAN'S REQUEST:** I request and authorize Department of Veterans Affairs to release the information specified below to the organization, or individual named on this request. I understand that the information to be released included information regarding the following condition(s):

DRUG ABUSE

ALCOHOLISM OR ALCOHOL ABUSE

TESTING FOR OR INFECTION WITH

HUMAN IMMUNODEFICIENCY VIRUS  
(HIV)

SICKLE CELL  
ANEMIA

**INFORMATION REQUESTED:** (Check applicable box(es) and state the extent or nature of the information to be disclosed, giving the dates or approximate dates covered by each)

Copy of Hospital Summary

Copy of Outpatient Treatment Note(s)

Other

Tx Summary: Initial Assessment, Diagnoses, medications, Treatment plan, UA results, attendance, discharge summaries. Reporting of progress during the course of treatment.

**Purpose(s) or need for which the information is to be used:**

Assist client in meeting legal requirements

Coordination of Care

Transfer Tx to another agency

Assist with housing application  Other:

**AUTHORIZATION:** I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time except to the extent that action has already been taken to comply with it. Redisclosure of my medical records by those receiving the above authorized information may not be accomplished without my further written consent. Without my express revocation, the consent will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on \_\_\_\_\_ (date supplied by patient: or (3) under the following condition(s):

Date:

X

Signature of Patient or Person Authorized to Sign for Patient

X

FOR VA USE ONLY

IMPRINT Patient Data Card (Name, Address, Social Security Number)

Type and Extent of Material Released

Date Released

Released By:



Department of Veterans Affairs

# APPLICATION FOR HEALTH BENEFITS

## SECTION GENERAL INFORMATION

**Federal law provides criminal penalties, including a fine and/or imprisonment for up to 5 years, for concealing a material fact or making a materially false statement. (See 18 U.S.C. 1001)**

1. VETERAN'S NAME (Last, First, Middle Name)		2. OTHER NAMES USED		3. MOTHER'S MAIDEN NAME		4. GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
5. ARE YOU SPANISH, HISPANIC, OR LATINO? <input type="checkbox"/> YES <input type="checkbox"/> NO		6. WHAT IS YOUR RACE? (You may check more than one.) (Information is required for statistical purposes only.) <input type="checkbox"/> AMERICAN INDIAN OR ALASKA NATIVE <input type="checkbox"/> BLACK OR AFRICAN AMERICAN <input type="checkbox"/> ASIAN <input type="checkbox"/> WHITE <input type="checkbox"/> NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER					
7. SOCIAL SECURITY NUMBER		9. DATE OF BIRTH (mm/dd/yyyy)			10. RELIGION		
8. CLAIM NUMBER		9A. PLACE OF BIRTH (City and State)					
11. PERMANENT ADDRESS (Street)			11A. CITY		11B. STATE	11C. ZIP CODE (9 digits)	
11D. COUNTY		11E. HOME TELEPHONE NUMBER (Include area code)			11F. E-MAIL ADDRESS		
11G. CELLULAR TELEPHONE NUMBER (Include area code)			11H. PAGER NUMBER (Include area code)				
12. TYPE OF BENEFIT(S) APPLIED FOR (You may check more than one) <input type="checkbox"/> HEALTH SERVICES <input type="checkbox"/> NURSING HOME <input type="checkbox"/> DOMICILIARY <input type="checkbox"/> DENTAL							
13. IF APPLYING FOR HEALTH SERVICES OR ENROLLMENT, WHICH VA MEDICAL CENTER OR OUTPATIENT CLINIC DO YOU PREFER?							
14. DO YOU WANT AN APPOINTMENT WITH A VA DOCTOR OR PROVIDER AS SOON AS ONE BECOMES AVAILABLE? <input type="checkbox"/> YES <input type="checkbox"/> NO I am only enrolling in case I need care in the future.				15. HAVE YOU BEEN SEEN AT A VA HEALTH CARE FACILITY? <input type="checkbox"/> YES, LOCATION: <input type="checkbox"/> NO			
16. CURRENT MARITAL STATUS (Check one) <input type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> UNKNOWN							
17. NAME, ADDRESS AND RELATIONSHIP OF NEXT OF KIN				17A. NEXT OF KIN'S HOME TELEPHONE NUMBER (Include area code)			
				17B. NEXT OF KIN'S WORK TELEPHONE NUMBER (Include area code)			
18. NAME, ADDRESS AND RELATIONSHIP OF EMERGENCY CONTACT				18A. EMERGENCY CONTACT'S HOME TELEPHONE NUMBER (Include area code)			
				18B. EMERGENCY CONTACT'S WORK TELEPHONE NUMBER (Include area code)			
19. INDIVIDUAL TO RECEIVE POSSESSION OF YOUR PERSONAL PROPERTY LEFT ON PREMISES UNDER VA CONTROL AFTER YOUR DEPARTURE OR AT THE TIME OF DEATH. NOTE: THIS DOES NOT CONSTITUTE A WILL OR TRANSFER OF TITLE (Check one) <input type="checkbox"/> EMERGENCY CONTACT <input type="checkbox"/> NEXT OF KIN							