New Philadelphia Municipal Recovery Court Program

Application Screening Form

1. Screening Date: ___/___/___ **Case #:** _____

2. Full Name: _____

3. Social Security Number: _____ - _____ - _____

4. Gender: Male Female **5. Date of Birth:** ____/____/____ **6. Marital Status:** _____

7. Telephone #'s: (home) _____ **(cell)** _____ (work) _____

8. Address: _____

_____

9. Do you live with other people at this address? ☐ **NO** ☐ **YES**→*If yes*, complete the table below

NAME	AGE	RELATIONSHIP	DRUG & ALCOHOL USE	MENTAL ILLNESS	PHYSICAL ILLNESS

10.How many children do you have? _____ **Age(s) of children**: _____

Do you have custody of your children? ☐ **YES** ☐ **NO**

11. How long have you lived at this address? _____

12. Are you willing to/able to relocate, if necessary, to a safer environment? ☐ **YES** ☐ **NO**→ *If no*, state reason _____

13. Do you have a valid Driver's License? ☐ **YES** ☐ **NO** → *If no*, state reason _____

14. Do you have your own transportation? ☐ **YES** ☐ **NO**
If no, do you have another source of reliable transportation? ☐ YES ☐ NO

15. Are you currently employed?

☐ Yes ☐ full time ☐ part time Employer: _____ Hire date: _____

☐ No – looking for work ☐ No- disabled ☐ No- retired ☐ No- not looking ☐ Other: _____

16. Are you currently attending school? ☐ YES ☐ NO

If yes → ☐ full time ☐ part time School: _____

Highest level of education (or grade) completed : _____

17. Do you have health insurance? ☐NO ☐YES →*insurance provider*: _____

18. Approximately how much money do you receive from the following sources each month?

Employment $ _____.00
Public assistance $ _____.00
Retirement/Social Security $ _____.00
Disability $ _____.00
Unemployment $ _____.00
Child Support $ _____.00
Other $ _____.00

19. Emergency contact: _____ Relationship: _____

Address: _____ Phone: _____

20. Do you have any alcohol/drug-free peers? ☐YES ☐NO

21. Do you have a problem with alcohol and /or drug use? ☐YES ☐NO

22. Are you willing to be in a treatment program for 12 to 18 months? ☐ YES ☐ NO

23. Are you able to attend Recovery Court review hearings at 11:00am on Wednesdays? ☐YES ☐ NO

24. Criminal History: Begin with the most recent charge(s),

Date of arrest	Charge(s)	Felony or Misdemeanor	Time Served	Outcome Parole/ Probation	PO's Name

25. Substance Use/Abuse/Dependency/Addiction History:

Substance	Age at First Use	Age/Date of Last Use	Frequency (Times/Month)	Daily Use? Yes/No	Quantity	Method of Use
Alcohol						
Marijuana						
Cocaine						
Heroin						
Suboxone						
Methadone						
Methamphetamine						
Ecstacy/MDMA						
Inhalants						
Spice						
Bath Salts						
Hallucinogens (LSD, PCP, acid)						
Prescription Medication (Vicodin, OxyContin, Ultram, Xanax, Addreall, Ritalin, etc.)						
Over-the-Counter Medication (DXM/ Robitussin, codeine, cough syrup, diet pills, etc.)						

26. List substances in order by drug of choice: 1. _____ 2. _____

3. _____ 4. _____

27. Have you ever received treatment services for drug problems? ☐ **NO** ☐ **YES**→*If yes*, complete table

Treatment Facility	Inpatient/Outpatient	Date	Contact Person	Completed (YES/NO)

28. Have you ever been diagnosed with a mental illness? ☐YES ☐ NO

If yes, when, by whom and what was the diagnosis: _____

_____

29. Do you have any current physical health problems? ☐YES ☐NO

If yes, please explain: _____

_____

30. What goals do you want to achieve in life? _____

_____

_____

31. Please provide any other information you believe is important to your current situation:

_____

_____

Defendant's signature: _____ **Date:** _____

Rev. 12/13/16