

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? _____

* Active Case(s) in other courts? Yes No If yes, please describe what and where: _____

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

(Required information, not used for disqualification)

*** RACIAL/ETHNIC BACKGROUND:**

Select all that apply:

- African American Hispanic
 Alaskan Native Native-American
 Asian/Pacific Islander Other
 Caucasian

***IDENTIFY GENDER AS:**

Select all that apply:

- Male
 Female
 Non-Binary/Non-Conforming
 Transgender

***MARITAL STATUS:**

- Single Separated
 Married Widowed
 Divorced

***EDUCATIONAL STATUS**

- No high school diploma or GED Associate Degree
 High school diploma Bachelor Degree
 GED Advanced Degree
 Some college

***EMPLOYMENT STATUS**

- Unemployed Not in labor Force
 Employed Full Employed Part Time

***FOSTER CARE**

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

***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**

- No
- Yes

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: _____

*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

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 Assisted 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 a 12 month intensive program, which includes substance abuse treatment, drug testing, regular reports to a probation agent, treatment court sessions, education and employment?

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 If no, please explain: _____

**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? _____

ORAS Self-Report Survey-Community Supervision Assessment Tool

Name: _____

The following questions ask about several things in your life, such as education, employment, family, friends and your beliefs. Please answer the following questions the best you can. There are no right or wrong answers to these questions. Some questions will be simple yes or no questions and others will ask you to circle a number which corresponds to how much that statement reflects your beliefs or is “true” for you.

- Highest Education
 Less than 12th Grade
 High School Graduate
 GED
 College
- In school were you ever suspended or expelled? Yes____ No____
- How long have you lived at your current address?_____
- How many address changes have you had in the past 12 months ? (do not count jail/prison)_____
- What is the age you began regularly using alcohol?_____
- How long has it been since you last drank alcohol?_____
- What is the longest period of time you have abstained form drinking?_____
- What percent of your close friends have been in trouble with the law?_____ %
- Would you say you live in a “high crime” neighborhood? Yes____ No____
- Were you employed at the time of your arrest? Yes____ No____
- If yes, how many hours per week did you work?_____
- Are you currently employed? Full Time_____ Part Time_____
No, I am on disability_____ No. I am retired_____ No, not currently employed_____
- In your opinion, do you have a lot of free time? Yes____ No____
- On average, approximately what percent of your week is considered free time?_____ %

For the following statements circle the answer that best describes how you feel

- How easy would you say it is to acquire drugs in your neighborhood?
Very Easy
1 2 3 4
Very Difficult

16. Are you satisfied with your current marital status? (If single, how satisfied are you with being single?)
 Not Satisfied 1 2 Very Satisfied 3 4
17. How would you rate your current financial stability?
 Cannot pay bills 1 2 Can pay bills and have extra money 3 4
18. Are you satisfied with current housing situation?
 Not Satisfied 1 2 Very Satisfied 3 4
19. Please Rate the level of emotional and personal support you receive from family and friends
 No Support 1 2 Very Satisfied 3 4
20. Please rate how satisfied you are with the level of support you receive from family and friends
 Not Satisfied 1 2 Very Satisfied 3 4
21. I'm often upset when I hear about other people's problems.
 Strongly Agree 1 2 Strongly Disagree 3 4
22. Do you think it is ever ok to lie?
 Never or only white lies 1 2 It is ok to lie 3 4
23. Lately, I have felt a lack of control over events in my life.
 Strongly Agree 1 2 Strongly Disagree 3 4
24. I sometimes find it exciting to do things for which I might get in trouble.
 Strongly Agree 1 2 Strongly Disagree 3 4
25. Would others describe you as someone who walks away from a fight or the first to get into it?
 Walks Away 1 2 First one in 3 4
26. How much do you agree with the statement "do unto others before they do unto you"?
 Strongly Agree 1 2 Strongly Disagree 3 4

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: _____