MILWAUKEE COUNTY VETERANS TREATMENT COURT ELIGIBILITY APPLICATION

Submit completed form via fax, e-mail or US mail to:

Jacob Patten
Veterans Treatment Court Coordinator
Safety Building Rm 308
821 W State Street
Milwaukee, WI 53233
Phone: (414) 278-2061
Fax: (414) 937-2753
Email: jacob.patten@wicourts.gov

Did you ever serve in the United States Armed Forces (Army, Marines, Navy, Air Force, Coast Guard, National Guard or Reserves?)

○ **Yes** ○ **No** **If yes, what branch?** _____

Last Name: _____ First Name: _____

DOB: _____ Phone: _____ Veterans e-Mail:_____

Home Address: _____ City: _____ State: _____ ZIP: _____

Alternate phone: _____ Legal Case # (ex: 2017CF1234): _____

What is the Veteran charged with? _____

Defense Attorney Name: _____ Phone: _____ e-Mail: _____

Ethnicity: Hispanic or Latino ○ Not Hispanic or Latino ○

Race: (mark one or more) American Indian or Alaskan Native ○ Asian ○ Pacific Islander ○
Black or African American ○ White ○ Other ○

Are you currently on Community Supervision? _____Agent's Name_____

Military History

1. When did you first enter the U. S. Armed Forces? Month / Year: _____
2. When were you discharged last? Month / Year: _____
3. Altogether, how much time did you spend in the U. S. Armed Forces? Number of: Years: _____ Months:____ Days: _____
4. What type of discharge did you receive?
   - ○ Honorable ○ General (Under Honorable Conditions) ○ Dishonorable / Other than Honorable
   - ○ Bad Conduct ○ Entry Level Separation / Uncharacterized ○ Don't know
   - ○ Other – Specify _____
5. Where were you discharged? State: _____ County: _____
6. Have you ever received services at a VA Medical Center or Clinic?
   - ○ Yes – Where? _____ When? _____
   - ○ No
7. Do you have a service connected disability?
   Yes ○ No ○
   If yes what percentage % _____
8. Are you currently employed?
   Yes ○ No ○
   If yes, where? _____

I authorize the program coordinator to obtain verification of my military service and benefits for purposes of determination of my possible eligibility into the Milwaukee County Veterans Treatment Court. **Also complete the attached release of information for both the VTC and VA and submit it with this form**.

_____ _____ _____
Print Name Sign Name Date

MILWAUKEE COUNTY VETERANS TREATMENT COURT PROGRAM
AUTHORIZATION TO RELEASE OR RECEIVE INFORMATION
(Pursuant to Title 42 of the Code of Federal Regulations (CFR), Part 2)

I _____ _____
(Print complete name) (Date of Birth)

As named above, I consent to the communication and disclosure of records pertaining to my admittance into and participation while in the Milwaukee County Veterans Treatment Court (VTC) Program, as well as any records pertaining to treatment I receive while in the program between the Milwaukee County Veterans Treatment Court and:

Referred Treatment Agency; VTC case managers; Milwaukee County Circuit Court Judges; District Attorney's office; Public Defender's office; Defense Attorney; Milwaukee. County CJF/HOC (WellPath); Milwaukee Secured Detention Facility; Milwaukee Police Dept.; Milwaukee. County Behavioral Health Division; Milwaukee. VA; Center for Veterans Issues; Wisconsin Community Services; WI-Department of Corrections; Wisconsin Department of Veterans Affairs; Veteran Court Peers; Difference Principal Network (& subsidiaries); Milwaukee County Veterans Service Office (MCVSO); & UW-Milwaukee Evaluations

For the purpose of:

Community Service Referrals	Application for Services
AODA Diagnosis/Treatment	Obtain/Maintain Employment
Treatment Planning	Work or School Reports
Social, Vocational and Fiscal planning	Legal
Stabilization Services	Obtain or Maintain Housing
Mental Health Diagnosis/Treatment	Work/School Reports
Verification of Military Service	Resident Status

Scope of Release:

Dates of Services and Participation
Evaluations
Diagnoses
Treatment Attendance
Progress Notes
Compliance
Medical History and Medications

I understand that this consent will remain in effect until there has been a formal and effective termination of my involvement with the Milwaukee County Veterans Treatment Court. I also understand that I may revoke this consent at any time. Any revocation must be in writing. I understand I will not be allowed to participate in the Milwaukee County Veterans Treatment Court if I refuse to consent to this disclosure.

I understand that Part 2 of Title 42 of the Code of Federal regulations, which governs the confidentiality of substance abuse client's records, binds any disclosure. Recipients of this information may disclose it only in connection with their official duties.

_____
Signature of Veteran Participant Date

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

PRIVACY ACT AND PAPER WORK REDUCTION ACT INFORMATION: The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Act. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless is displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 2 minutes. This includes the time it will take to read the instructions, gather the necessary facts and fill out this form. 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. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164; 5 U.S.C. 552a; and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if information needed to locate records for release is not furnished completely and accurately, VA will be unable to comply with the request. The Veterans Health Administration may not condition the provision of treatment, payment, enrollment in the VA Health Care Program, or eligibility for benefits on the signing of an authorization, except for research-related treatment where an authorization for the use or disclosure of individually-identifiable health information for such research is required. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act system of records notices identified as 24VA10A7 "Patient Medical Record - VA", 08VA05 "Employee Medical File System Records (Title 38)-VA" and in accordance with the Notice of Privacy Practices. VA may also use this information to identify Veterans and person claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

TO: DEPARTMENT OF VETERANS AFFAIRS *(Name and Address of VA Health Care Facility)*

Clement J. Zablocki VAMC
5000 W. National Ave
Milwaukee, WI 53295

LAST NAME- FIRST NAME- MIDDLE NAME	DATE OF BIRTH *(mm/dd/yyyy)*

PATIENT'S MAILING ADDRESS (*including City, State and Zip Code*)

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

Milwaukee County Veteran Treatment Court Team: Milw. Cnty Circuit Court Judges; DA's office; Public Defender's office; Vet's Attorney; Milw. Cnty Jail/HOC(WellPath); MSDF; Milwaukee Police Dept.; Milw. Cnty Behavioral Health Division; CVI; WCS; WI-DOC; WDVA; Veteran Court Peers; Difference Principal Network (& subsidiaries); & UW-Milwaukee

PURPOSE(S) OR NEED: Information is to be used by the requestor for:

☒ TREATMENT ☐ BENEFITS ☒ LEGAL ☐ EMPLOYMENT ☒ OTHER *(Please specify)* UW-Milw. for research

INFORMATION REQUESTED: Check applicable box(es) and state the extent or nature of information to be provided:

☒ HEALTH SUMMARY *(Prior 2 Years)*

☒ INPATIENT DISCHARGE SUMMARY *(Dates)*: all

☒ PROGRESS NOTES:

- ☒ SPECIFIC CLINICS *(Name & Date Range)*: all
- ☒ SPECIFIC PROVIDERS *(Name & Date Range)*: all
- ☒ DATE RANGE: all

☒ OPERATIVE/CLINICAL PROCEDURES *(Name & Date)*: all

☒ LAB RESULTS:

- ☒ SPECIFIC TESTS *(Name & Date)*: all
- ☒ DATE RANGE: all

☒ RADIOLOGY REPORTS *(Name & Date)*: all

☒ LIST OF ACTIVE MEDICATIONS: all

☒ FLU VACCINATION *(Dose, Lot Number, Date & Location)*: all

☒ OTHER *(Describe)*: all information as relevant to legal proceedings

LAST NAME- FIRST NAME- MIDDLE NAME	DATE OF BIRTH *(mm/dd/yyyy)*

SENSITIVE DIAGNOSES: REVIEW AND, IF APPROPRIATE, COMPLETE WHEN RELEASE IS FOR ANY PURPOSE OTHER THAN TREATMENT.

I request and authorize Department of Veterans Affairs to release the information pertaining to the condition(s) below for the non-treatment purpose(s) listed in this authorization.

☒ DRUG ABUSE ☒ ALCOHOLISM OR ALCOHOL ABUSE ☐ SICKLE CELL ANEMIA

☐ HUMAN IMMUNODEFICIENCY VIRUS *(HIV)*

I understand that information on these sensitive diagnoses may be released for treatment purposes without me checking the above boxes, and will be released even if the boxes are unchecked unless I indicate by checking the box below that I do not want this information released for this specific disclosure.

☐ **I do not want sensitive diagnoses released for treatment purposes under this specific authorization. I realize this does not impact other future requests unrelated to this authorization.**

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing records. Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

I understand that the VA health care provider's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions.

EXPIRATION: Without my express revocation, the authorization will automatically expire *(select one of the following)*:

☐ AFTER ONE-TIME DISCLOSURE, IF ALL NEEDS ARE SATISFIED

☐ ON *(mm/dd/yyyy)* _____ *(enter a future date other than date signed by patient)*

☒ UNDER THE FOLLOWING CONDITION(S): Until no longer justice involved or incarcerated as related to case(s) that the Veteran Justice Outreach program is providing assistance

PATIENT SIGNATURE *(Sign in ink)*	DATE *(mm/dd/yyyy)*
LEGAL REPRESENTATIVE SIGNATURE (*if applicable) (Sign in ink*)	DATE *(mm/dd/yyyy)*
PRINT NAME OF LEGAL REPRESENTATIVE	RELATIONSHIP TO PATIENT

FOR VA USE ONLY

TYPE AND EXTENT OF MATERIAL RELEASED

DATE RELEASED *(mm/dd/yyyy)*	RELEASED BY:

Milwaukee VTC Transportation Plan

Name:_____

(For OWI Offenses Only) In order to get my driver's license back, I will need to do the following:

1._____

2._____

3._____

4._____

5._____

I do not currently have my driver's license and must make alternative transportation plans.

I need transportation to meet my Veterans Treatment Court obligations as well as other obligations as follows:

PURPOSE	DAY(S) of the WEEK	TIME	MEANS OF TRANSPORTATION

____ _____(SIGNATURE)