

MARION COUNTY ADULT DRUG COURT PROGRAM APPLICATION

Marion County Judicial Center
110 NW 1st Avenue, Room 1-1062, Ocala, Florida 34475

APPLICATIONS WILL BE REVIEWED BY DRUG COURT STAFF & THE STATE ATTORNEY'S OFFICE

IMPORTANT: Defendant must review the brochures for the drug court program for which they, and (if applicable) their defense attorney, believe the defendant qualifies.

The following are brief overviews of the application procedures followed for each Marion County Drug Court:

1. **MARION MISDEMEANOR DRUG COURT (MDC):** Defendant contacts the Court Case Manager at (352)401-8146 to schedule a review of the application and program screening. The applicant will deliver the attached Application, Release of Information and the \$25.00 non-refundable application fee to the Drug Court Office at Marion County Judicial Center (address & room below) at the time of their appointment. **(The application fee for this program must be paid prior to or at the time of the applications submission)**. The application is forwarded to the State Attorney's Office to determine legal qualification and will also be reviewed by the Misdemeanor Drug Court Staffing Team which may include the defendants legal counsel and the presiding Judge. The presiding Judge will review the recommendation of the Drug Court Staffing Team and the Assistant States Attorney advises the Team s to the State's position of the defendant's application. A written recommendation is made to the trial judge together with a proposed order of reassignment if applicable.
2. **FELONY DIVERSION DRUG COURT (FDDC):** This program is a Felony Pre-Plea, Pre-Adjudication Drug Court. Defendant contacts the Court Case Manager at (352)401-7886 to schedule a review of the application and program screening. The applicant will mail, have hand delivered or send the attached Application and Release of Information to the Drug Court Office at Marion County Judicial Center (address & room below). There is no application fee for this program however there is a \$60.00 monthly fee due at the beginning of each month that the defendant is in the program. The application is forwarded to the State Attorney's Office to determine legal qualification and will also be reviewed by the Drug Court Staffing Team which may include the defendants legal counsel and the presiding Judge. The presiding Judge will review the recommendation of the Drug Court Staffing Team and the Assistant States Attorney advises the Team s to the State's position of the defendant's application. A written recommendation is made to the trial judge together with a proposed order of reassignment if applicable. The presiding Judge may also execute a transfer order placing the defendant on the Felony Diversion Drug Court Docket.
3. **ADULT FELONY POST ADJUDICATORY (& PRE-TRIAL) DRUG COURT (AFDC / Non Expansion Drug Court):** Defendant may contact the Court Case Manager at (352)401-6729 to schedule a review of the program or the application. The applicant will mail, have hand delivered or send the attached Application and Release of Information to the Drug Court Office at Marion County Judicial Center (address & room below). The application fee for this program* is \$35.00 with a monthly fee of \$135.00 due at the beginning of each month that the defendant is in the program. The completed application is forwarded to the State Attorney's Office to determine legal qualification for this specific program and may also be reviewed by the Drug Court Staffing Team which may include the defendants legal counsel and the presiding Judge.
4. **EXPANSION DRUG COURT PROGRAM (in lieu of prison):** Defendant may contact the Court Case Manager at (352)401-6725 or (352)401-7894 to schedule a review of the program or the application. The applicant will mail, have hand delivered or send the attached Application and Release of Information to the Drug Court Office at Marion County Judicial Center (address & room below). The application fee for this program* is \$35.00 with a monthly fee of \$25.00 due at the beginning of each month that the defendant is in the program. The completed application is forwarded to the State Attorney's Office to determine legal qualification for this specific program and may also be reviewed by the Drug Court Staffing Team which may include the defendants legal counsel and the presiding Judge.
5. Once accepted into the program the defendant attends the next regularly scheduled Drug Court hearing as instructed by court order and Drug Court Case Manager.
6. **FEES:** All Marion Drug Court application or Drug Court Fees are non-refundable and shall be in the form of a Money Order made payable to: MARION COUNTY BOCC. Credit and Debit Cards also accepted.

***Application fees for AFDC and Expansion Drug Courts (#s 3 & 4 only) may be submitted once the participant has been accepted in the program.**

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IMPORTANT: Please indicate the drug court program for which you or your defense counsel feel you qualify**
(*see program brochures for details on qualifying or disqualifying factors)

<input type="checkbox"/> Adult Misdemeanor Drug Court	<input type="checkbox"/> Adult Felony Diversion Drug Court (pre-plea/pre-adjudication)	<input type="checkbox"/> Adult Felony Post Plea Drug Court	<input type="checkbox"/> Post-Adjudicatory Expansion Drug Court
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1. PERSONAL INFORMATION: (PLEASE PRINT)

First Name: _____ Middle: _____ Last Name: _____ Suffix: _____

Aliases: _____

Social Security # (last four): _____ DL State: _____, DL/ID# _____ Status: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number(s): _____ Cell: _____, email address: _____

Living arrangement: Independent, Homeless, Dependent with (Name/Relationship): _____

Gender: Male, Female, Other Date of Birth: ____/____/____

Marital Status: Single Married Separated Divorced Widowed

Race/Ethnicity: African American, Caucasian, Multi-Racial, Asian/Pacific
 Hispanic/Latino, Native American, Other: _____

Partner/Spouse's Name: _____

CHILDREN: (Use last page if more space is needed)

Name: _____ Lives with applicant: Yes, No, Lives with: _____

Attending School: Yes, No, School Attending: _____

DOB: ____/____/____ Age: _____ Gender: Male, Female, Other

Name: _____ Lives with applicant: Yes, No, Lives with: _____

Attending School: Yes, No, School Attending: _____

DOB: ____/____/____ Age: _____ Gender: Male, Female, Other

Name: _____ Lives with applicant: Yes, No, Lives with: _____

Attending School: Yes, No, School Attending: _____

DOB: ____/____/____ Age: _____ Gender: Male, Female, Other

Child Support: N/A, Paying Current, Paying NOT Current, Not Paying, Support Enforcement

Others residing in the home not already listed above:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

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2. CRIMINAL HISTORY: (PLEASE PRINT)

Have you ever been charged with a Violent Crime or Sex Offense, Other than Domestic Violence? Yes, No

If YES: What Offense: _____

Previous Conviction of Domestic Violence: Yes, No Outstanding Warrants: Yes, No

Currently on Probation: Yes, No Probation Officer: _____

Previous Court Failure to Appear (FTA): Yes, No. # of FTA: _____ Previous VOP: Yes, No

Pending Criminal Charges in another county: Yes, No, If Yes, County: _____

If yes to charges in another county, what charges: _____

Name of Judge CURRENTLY assigned to the criminal case: _____

DATE OF ARREST	CURRENT CHARGES (list all)	COURT CASE #(s):

DATE OF ARREST	CRIMINAL HISTORY (list all charges)	CITY/STATE

DEPENDENCY COURT:

Current DEPENDENCY Case? Yes, No FFN Case Worker Name: _____

Has there ever been a Dependency Case? Yes, No If Yes, year & outcome: _____

PRIOR DRUG, VETERAN'S, MENTAL HEALTH or DUI COURT PARTICIPATION:

History of prior participation: _____ None, _____ Successful, _____ Unsuccessful, _____ Absconded,

Other: _____

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3. SUBSTANCE USE HISTORY: (PLEASE PRINT)

⇒ IMPORTANT: You MUST complete this section to be considered for DRUG COURT ⇐

Current Substance use: Yes, No

Prior Substance Use: Yes, No

Current IV Drug use: Yes, No

History of IV Drug use: Yes, No

Have you ever been under the influence of any substance when arrested? Yes, No

Age began using Alcohol: _____, Age began using any other substance: _____

Ever attended any substance abuse treatment program? Yes, No, Explain: _____

Current Medication(s): Yes, No, If yes, Treatment for: Physical, Psychological, Both

Medication(s): _____

Do you currently have a Marijuana Card? Yes, No. If Yes, Provider: _____

Ever been treated for substance use with a Medically Assisted Treatment (i.e. Methadone, Suboxone etc): Yes, No

MAT (Medically Assisted Treatment) medication used & prescribed by: _____

CIRCLE "1" FOR PRIMARY or PREFERRED DRUG OF CHOICE: (circle ALL that apply)

CIRCLE "2" FOR SECONDARY DRUG OF CHOICE: (circle ALL that apply)

CIRCLE "T" if you have EVER TRIED THIS SUBSTANCE: (circle ALL that apply)

1 = PREFERRED 2 = SECONDARY T = EVER TRIED			SUBSTANCE (Include even if prescribed)	AGE OF 1 ST USE	DATE OF LAST USE
1	2	T	Alcohol		
1	2	T	Marijuana-Cannabinoids		
1	2	T	Cocaine or Crack		
1	2	T	Methamphetamine		
1	2	T	RX: Stimulants – Amphetamines – Adderall, Ritalin etc.		
1	2	T	Methadone (include even if prescribed)		
1	2	T	RX: Opioids – Oxy, Roxy, Lortab, Fentanyl etc.		
1	2	T	Heroin		
1	2	T	Steroids or Inhalants		
1	2	T	Dissociative: Ketamine (Special K), PCP, DXM		
1	2	T	Salvia		
1	2	T	“Spice” – Synthetic Marijuana		
1	2	T	“Bath Salts”		
1	2	T	MDPV-“Molly”		
1	2	T	Hallucinogens: LSD, Mescaline, Psilocybin (Mushrooms) etc.		
1	2	T	MDMA (Ecstasy) Rohypnol, GHB		
1	2	T	RX: Depressants – Benzodiazepine – Xanax, Quaaludes, Valium etc.		
1	2	T	Kratom		
1	2	T	Tobacco (smoke, dip or chew)		
1	2	T	OTHER:		

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4. EMPLOYMENT HISTORY: (PLEASE PRINT)

Current Employment Status: ___ Full-Time, ___ Part-Time, ___ Unemployed, ___ Disabled, ___ Retired, ___ Student.

If Employed:

Name of current employer: _____

Average number of hours worked per week: _____, Length of time with current employer: _____ Months, _____ Years

Primary Source of Support:

___ Salary/wages, ___ Disability, ___ Family, ___ Foster Care Subsidy, ___ Adoption Subsidy, ___ Retirement Plan,
___ Social Security, ___ Social Security Disability, ___ Veteran's Benefits, ___ SNAP/AFDC, ___ Workers Comp,
___ None, ___ Other: _____

Employment History (previous job experience & why you are no longer employed there): _____

Type of work in which you are interested: _____

Describe any volunteer involvement you have had: _____

Describe community or church involvement for which you have been part: _____

MILITARY SERVICE

Years in service: _____ Branch & Rank: _____

Do you have a DD214? ___ Yes, ___ No, Discharge status: _____

Registered VA services: ___ Yes, ___ No

Other Military Information: _____

5. TRANSPORTATION STATUS: (PLEASE PRINT)

___ Reliable transportation, EXPLAIN: _____

___ No reliable transportation, If NO please EXPLAIN how you plan to get to treatment, work, drug screens & court etc.: _____

Current Valid Driver's License? ___ Yes, ___ No, if No, EXPLAIN: _____

If No current valid DL, what is needed to get your DL back: _____

Do you own or lease a vehicle: ___ Yes, ___ No, Make & Model of Vehicle(s): _____

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6. EDUCATION HISTORY: (PLEASE PRINT)

Highest Education Completed:

No High School Diploma; last year completed: _____ grade. GED, High School Diploma
 Some Trade School, Trade School Graduate, Major/Field: _____
 Some College, College Graduate 2 year Program, Major/Field: _____
 College Graduate 4 year program Major/Field: _____
 Advanced Degree Major/Field: _____
 Currently Attending School, Name of School: _____

If no high school diploma or GED, what caused you to drop out? _____.

Did you have an Individualized Educational Program (IEP) when in school? Yes, No, Unsure.

Any additional services provided while you were in school (tutor, specialized classes, counseling, other therapies)?
_____.

What difficulties/issues did you have in school if any? _____

7. HOME LIFE: (PLEASE PRINT)

Number of times moved in the past 3 years. _____ Comments: _____

Length of time at current primary address: _____ Comments: _____

Describe your home situation: _____

Do you have any close friends/family who you can trust to help you in recovery? Yes, No

Do you have close friends/family involved in the Criminal Justice/Court system? Yes, No

If yes to either of the above, who? _____

8. HEALTH & TRAUMA HISTORY:

History of Medical Condition(s): Yes, No, Explain: _____

Date of last Physical Exam: _____ Primary Care Physician: _____

History of Communicable Disease: Hep B, Hep C, Hep A, HIV, TB, COVID19, Other: _____

History of Mental Health Condition(s): Yes, No, Explain: _____

Medical Insurance: Yes, No, Provider: _____

Pregnant: Yes, No, N/A. Physician: _____

TRAUMA/LOSS: Has there been any significant trauma or loss in your life? (e.g. loss of family, friend, tragedy, abuse):

_____.

PLEASE DESCRIBE WHY YOU BELIEVE THIS PROGRAM WILL BENEFIT YOU: _____

_____.

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RELEASE OF INFORMATION

The purpose of, and need for, this exchange of information is to provide information about my eligibility for, and participation in this Marion County Drug Court Program application and screening process. The information to be exchanged may include information about any diagnosis which will include, but is not limited to; medical history, including current assessments, diagnosis, treatment and medications, arrests and prior criminal record, risk and alcohol and other substance use assessment and diagnostic information.

This Marion County Drug Court's team members are: The presiding Judge, Assistant State Attorney, Assistant Public Defender or other Defense Counsel, Court Case Manager/Coordinator, Court Administration Manager, Drug Court Staff, Local law enforcement representative, Marion County Probation and/or Department of Corrections. Also included are Recovery Community Organization, Treatment Providers and Program Evaluators as needed.

I agree that the disclosure of the Application Intake/Screening and Treatment information, prior to the Marion County Drug Court termination, sentencing and /or revocation of this consent shall not be a breach of my right to confidentiality.

I understand that any disclosure made regarding mental health and substance abuse treatment is bound by Part 2 of Title 42 of the Code of Federal Regulations (42CFR, part 2), which governs the confidentiality of mental health an substance abuse patient records and that recipients of this information may re-disclose it only in connection with their official duties, and only with respect to these particular criminal proceedings.

Signature of applicant

Date

Name of attorney (PLEASE PRINT)

Signature of attorney

Date

