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)

___**Adult Misdemeanor Drug Court**	___**Adult Felony Diversion Drug Court** (pre-plea/pre-adjudication)	___ **Adult Felony Post Plea Drug Court**	___ **Post-Adjudicatory Expansion Drug Court**

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 1ST 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): _____

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

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

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ADDITIONAL NOTES

(Please use this area if more space was needed from a previous section of the application &/OR to share anything else you feel in important for us to know)

NIDA Clinical Trials Network
The Tobacco, Alcohol, Prescription medications, and other Substance (TAPS) Tool

TAPS Tool Part 1

Web Version: 2.0; 4.00; 09-19-17

General Instructions:
The TAPS Tool Part 1 is a 4-item screening for tobacco use, alcohol use, prescription medication misuse, and illicit substance use in the past year. Question 2 should be answered only by males and Question 3 only be females. Each of the four multiple-choice items has five possible responses to choose from. Check the box to select your answer.

Segment:
Visit number:

1. In the PAST 12 MONTHS, how often have you used any tobacco product (for example, cigarettes, e-cigarettes, cigars, pipes, or smokeless tobacco)?

   ☐ Daily or Almost Daily ☐ Weekly ☐ Monthly
   ☐ Less Than Monthly ☐ Never

2. In the PAST 12 MONTHS, how often have you had 5 or more drinks containing alcohol in one day? One standard drink is about 1 small glass of wine (5 oz), 1 beer (12 oz), or 1 single shot of liquor. (Note: This question should only be answered by males).

   ☐ Daily or Almost Daily ☐ Weekly ☐ Monthly
   ☐ Less Than Monthly ☐ Never

3. In the PAST 12 MONTHS, how often have you had 4 or more drinks containing alcohol in one day? One standard drink is about 1 small glass of wine (5 oz), 1 beer (12 oz), or 1 single shot of liquor. (Note: This question should only be answered by females).

   ☐ Daily or Almost Daily ☐ Weekly ☐ Monthly
   ☐ Less Than Monthly ☐ Never

4. In the PAST 12 MONTHS, how often have you used any drugs including marijuana, cocaine or crack, heroin, methamphetamine (crystal meth), hallucinogens, ecstasy/MDMA?

   ☐ Daily or Almost Daily ☐ Weekly ☐ Monthly
   ☐ Less Than Monthly ☐ Never

5. In the PAST 12 MONTHS, how often have you used any prescription medications just for the feeling, more than prescribed or that were not prescribed for you? Prescription medications that may be used this way include: Opiate pain relievers (for example, OxyContin, Vicodin, Percocet, Methadone) Medications for anxiety or sleeping (for example, Xanax, Ativan, Klonopin) Medications for ADHD (for example, Adderall or Ritalin)

   ☐ Daily or Almost Daily ☐ Weekly ☐ Monthly
   ☐ Less Than Monthly ☐ Never

NIDA Clinical Trials Network
The Tobacco, Alcohol, Prescription medications, and other Substance (TAPS) Tool

TAPS Tool Part 2

Web Version: 2.0; 4.00; 09-19-17

General Instructions:
The TAPS Tool Part 2 is a brief assessment for tobacco, alcohol, and illicit substance use and prescription medication misuse in the PAST 3 MONTHS ONLY. Each of the following questions and subquestions has two possible answer choices- either yes or no. Check the box to select your answer.

1. In the PAST 3 MONTHS, did you smoke a cigarette containing tobacco? ☐ Yes ☐ No

If "Yes", answer the following questions:

a. In the PAST 3 MONTHS, did you usually smoke more than 10 cigarettes each day? ☐ Yes ☐ No

b. In the PAST 3 MONTHS, did you usually smoke within 30 minutes after waking? ☐ Yes ☐ No

2. In the PAST 3 MONTHS, did you have a drink containing alcohol? ☐ Yes ☐ No

If "Yes", answer the following questions:

a. In the PAST 3 MONTHS, did you have 4 or more drinks containing alcohol in a day?* (Note: This question should only be answered by females). ☐ Yes ☐ No

b. In the PAST 3 MONTHS, did you have 5 or more drinks containing alcohol in a day?* (Note: This question should only be answered by males). ☐ Yes ☐ No

*One standard drink is about 1 small glass of wine (5 oz), 1 beer (12 oz), or 1 single shot of liquor.

c. In the PAST 3 MONTHS, have you tried and failed to control, cut down or stop drinking? ☐ Yes ☐ No

d. In the PAST 3 MONTHS, has anyone expressed concern about your drinking? ☐ Yes ☐ No

3. In the PAST 3 MONTHS, did you use marijuana (hash, weed)? ☐ Yes ☐ No

If "Yes", answer the following questions:

a. In the PAST 3 MONTHS, have you had a strong desire or urge to use marijuana at least once a week or more often? ☐ Yes ☐ No

b. In the PAST 3 MONTHS, has anyone expressed concern about your use of marijuana? ☐ Yes ☐ No

4. In the PAST 3 MONTHS, did you use cocaine, crack, or methamphetamine (crystal meth)? ☐ Yes ☐ No

If "Yes", answer the following questions:

a. In the PAST 3 MONTHS, did you use cocaine, crack, or methamphetamine (crystal meth) at least once a week or more often? ☐ Yes ☐ No

b. In the PAST 3 MONTHS, has anyone expressed concern about your use of cocaine, crack, or methamphetamine (crystal meth)? ☐ Yes ☐ No

5. In the PAST 3 MONTHS, did you use heroin? ☐ Yes ☐ No

If "Yes", answer the following questions:

a. In the PAST 3 MONTHS, have you tried and failed to control, cut down or stop using heroin? ☐ Yes ☐ No

b. In the PAST 3 MONTHS, has anyone expressed concern about your use of heroin? ☐ Yes ☐ No

6. In the PAST 3 MONTHS, did you use a prescription opiate pain reliever (for example, Percocet, Vicodin) not as prescribed or that was not prescribed for you? ☐ Yes ☐ No

If “Yes”, answer the following questions:

a. In the PAST 3 MONTHS, have you tried and failed to control, cut down or stop using an opiate pain reliever? ☐ Yes ☐ No

b. In the PAST 3 MONTHS, has anyone expressed concern about your use of an opiate pain reliever? ☐ Yes ☐ No

7. In the PAST 3 MONTHS, did you use a medication for anxiety or sleep (for example, Xanax, Ativan, or Klonopin) not as prescribed or that was not prescribed for you? ☐ Yes ☐ No

If “Yes”, answer the following questions:

a. In the PAST 3 MONTHS, have you had a strong desire or urge to use medications for anxiety or sleep at least once a week or more often? ☐ Yes ☐ No

b. In the PAST 3 MONTHS, has anyone expressed concern about your use of medication for anxiety or sleep? ☐ Yes ☐ No

8. In the PAST 3 MONTHS, did you use a medication for ADHD (for example, Adderall, Ritalin) not as prescribed or that was not prescribed for you? ☐ Yes ☐ No

If “Yes”, answer the following questions:

a. In the PAST 3 MONTHS, did you use a medication for ADHD (for example, Adderall, Ritalin) at least once a week or more often? ☐ Yes ☐ No

b. In the PAST 3 MONTHS, has anyone expressed concern about your use of a medication for ADHD (for example, Adderall or Ritalin)? ☐ Yes ☐ No

9. In the PAST 3 MONTHS, did you use any other illegal or recreational drug (for example, ecstasy/molly, GHB, poppers, LSD, mushrooms, special K, bath salts, synthetic marijuana ('spice'), whip-its, etc.)? ☐ Yes ☐ No

If “Yes”, answer the following questions:

In the PAST 3 MONTHS, what were the other drug(s) you used?

Comments: