Fairfax County Veterans Treatment Docket
Participant Application

Date submitted to VTD Coordinator____

PERSONAL INFORMATION

Last Name: ______________________ First ____________________ Middle__________

Address ____

City______________________________ State _______ ZIP______________

Phone___________________ E-mail ____________________________________

DOB ___________________ SSN_______________________________________

Race

- ☐ White
- ☐ Black or African American
- ☐ Asian
- ☐ American Indian or Alaska Native
- ☐ Pacific Islander or Native Hawaiian
- ☐ Multiracial
- ☐ Unknown
- ☐ Other

Ethnicity (check only one)

- ☐ Hispanic or Latino/a
- ☐ Non-Hispanic or Latino/a
- ☐ Unknown

Gender (check only one)

- ☐ Male
- ☐ Female
- ☐ Other ________

MILITARY HISTORY

Branch **ARMY** **MARINES** **NAVY** **AIR FORCE** **COAST GUARD** **NATIONAL GUARD** **RESERVES**

Length of Service _____Years _____Months

Type of Discharge__________________ Date of Discharge: ____________

VA BENEFITS

Are you eligible for VA benefits? **Yes** **No** **Unsure**

If so, are you currently enrolled? **Yes** **No**

MODE OF TRANSPORATION

VTD program will usually require you to commute to Fairfax County Courthouse approx. 2-3 times a week.

Circle mode of transportation? **Public transportation** **Own/operate private vehicle** **Other** *please specify*________

How long in hours/minutes is your commute? ________________________________

Approx. cost of commute each way? **less than $10** **$10-$20** **More than $20**

PENDING FAIRFAX COUNTY CHARGES

Case Numbers & Next Court Dates____

Charge(s) ____

____

Arrest Date____

Defense Counsel: ____

Phone: ___________________________ E-mail: ____

CRIMINAL HISTORY

List any prior criminal involvement, beginning with the most recent. ***If necessary attached a separate sheet.***

Date: ______________________________ Charge: ____

Charge(s):

Result:

Date: ___________ Charge: ___________________________

Charge(s):

Result:

Date: ______________________________ Charge: ____

Description:

Result:

MENTAL HEALTH HISTORY (if applicable) ***If necessary attached a separate sheet.***

Diagnosis: ____Date: ______________

Treatment Provider:

Phone:

Treatment History:

SUBSTANCE ABUSE HISTORY (if applicable) ***If necessary attached a separate sheet.***

Diagnosis:

Substance(s) of Choice:

First Use:

Last date of Use:

Treatment History:

IMPORTANT: Please attach a copy of your most recent DD-214; if you have the four-page version DD-214, submit page 4. If you have the older single-page version, submit that.

Questions? Please contact: **Brooke Postlewaite, Docket Coordinator, Fairfax County Veterans Treatment Docket, Fairfax County Courthouse; Rm 214; 703-246-2592** brooke.postlewaite@fairfaxcounty.gov

FAIRFAX COUNTY

COURT AUTHORIZATION FOR EXCHANGE OF INFORMATION

This form is to be used when participation in treatment is a condition of the disposition of criminal proceedings, probation, or release. The provision of treatment, payment, enrollment, or eligibility for benefits does not depend on whether I sign this form; however, if I do not sign this form, the Court may order disclosure of my information.

I, ____________________________________ **Date of Birth** _____________ **Case No.**_____________
Individual's Name (Please Print)

of____ _________________________
Address *(Phone)*

1. Authorize the exchange of ☒ All records/information listed below OR ☐ Only the records/ information checked below:

☒	**All Medical Records**	☒	**All Substance Use Treatment Information**
☒	**Mental Health Records**	OR the following substance use information only:	
☒	**Criminal Justice Information**	☐	Medications and dosages
☐	Other: ___________________	☐	Diagnosis/Substance Use History
☐	Other: ___________________	☐	Admission Summary/ Discharge Summary
		☐	Lab Tests and Results

2. Exchange among ☒ All entities listed below OR ☐ Only the entities checked below *(at least two):*

Except for entities that have a treating provider relationship with me, information may only be exchanged with individuals within the criminal justice system who have a need for the information in connection with their duty to monitor my progress.

	Treating Providers (Only entities that are treating you)		**Non-Treating Providers** (Must name individuals)
☒	Community Services Board (CSB)	☒	Probation or pretrial officer: _VTD assigned JDR & General District Court Services Officers _________________________
☒	Sheriff's Office	☒	Defense attorney: Negin Farahmand & Amy Jordan
☒	Health Department	☒	Prosecuting attorney: Bridget Corridon_
☒	All past, current, or future treating providers	☒	Program Evaluator: Lisa Lunghofer________
☒	Other Entity or individual(s): US Dept of Veterans Affairs	☒	Judge: Judge Azcarate, Judge Lindner & Judge Petit
		☒	Other individual(s): Virginia Dept of Veterans Services__

3. For the purpose of:

☒ Court-Ordered Treatment ☒ Probation/Pretrial Supervision

☒ Probation/Pretrial Reports ☒ Disposition of Criminal Proceedings

☒ For the sharing of information in a database for scientific research, and the sharing of (non-substance use treatment) information for proper purposes as defined by the Government Data Collection and Dissemination Practices Act; and/or

☒ Other *(specify purpose):* Fairfax County Veterans Treatment Docket Activities___________

4. This authorization is in effect until 1 year from signature date_**(*date or event*)**; and the authorization is unlimited for the sharing of information in a research database, if such sharing has been authorized above.

5. I understand that:

- Information disclosed shall not be used for any other purpose or disclosed to others not checked above. Except as authorized by 42 CFR Part 2, use of information disclosed to criminally investigate or prosecute any substance use disorder patient is prohibited.
- HIPAA information disclosed based on this authorization may be subject to re-disclosure and no longer protected. Substance use disorder information disclosed may only be re-disclosed and used to carry out the disclosing individual's official duties with regard to my conditional release.
- Providers using or disclosing information and records based on this authorization are to share only the necessary amount of information to accomplish the purpose of the disclosure.
- If I made a general designation of recipients of my substance use treatment information, I may request a list of entities to which my information has been disclosed.
- The information to be released has been explained to me and is given of my own free will.

6. I may revoke or cancel this authorization after final disposition of my conditional release by submitting a statement to any of the entities listed above, except to the extent that action has already been taken based on this authorization.

I have been given a copy of this authorization, or a copy has been placed in my file at the ADC or CSB.

7(a). Individual's Signature: ______________________________________ Date:________________

7(b). Other Signature: ____ Date:_________________

Other Signee's Role (must designate if signed by third party): ☐ *Parent* ☐ *Guardian* ☐ *Authorized Representative*

8. Staff accepting/recording form:

____

Printed Name *Signature (include credentials)* *Date*

Staff: Individual's copy in file: ☐ Yes ☐ No -- Requested and given at release: ☐ Yes ☐ No

For Internal Use Only: Record of Revocation of Authorization

Date authorization revoked/terminated: ___________________________ *Date parties notified:* ______