Ottawa County Court of Common Pleas
Specialized Docket Application

This application is for individuals applying for Mental Health Court or Drug Court

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Applicant Information:

Full Name: _____ Date: _____
(first) (middle) (last)

SSN: _____ DOB: _____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic Gender: ☐ Man ☐ Woman ☐ Non-binary

Race: ☐ White ☐ Black ☐ Native American ☐ Asian or Pacific Islander ☐ Unknown/Other

Home Address: _____

_____

Phone Number(s): 1._____ ☐Home ☐Cell ☐Other: _____

2._____ ☐Home ☐Cell ☐Other: _____

Who lives with you (please list everyone who lives in your household):

Name	Relation to you	Age	Phone

Does anyone in your household drink and/or use drugs? ☐ Yes ☐ No

If yes, who: _____

Are you willing to/able to relocate, if necessary, to a safer environment? ☐ Yes ☐ No

If no, state reason: _____

Current Legal Status:

- ☐ Pending Change of Plea and/or Sentencing
- ☐ Community Control Violation/Revocation
- ☐ Motion for Judicial Release

Case Number, Offense, and Degree of Felony and/or Misdemeanor: _____

_____

_____

_____

Next Court Hearing Date/Time: _____

Defense Attorney: _____

Do you have any pending legal issues in any other county? ☐ Yes ☐ No

If yes, which county(s) and what type(s) of charge(s): _____

_____

_____

_____

Valid Driver's License: ☐ Yes ☐ No

If no, state reason: _____

_____

Do you have your own transportation? ☐ Yes ☐ No

If no, do you have another source of reliable transportation? ☐ Yes ☐ No

How will you get to hearings and program activities? _____

_____

_____

Are you able to attend Status Review Hearings between 2:30-4:30pm on Thursdays? ☐ Yes ☐ No

Have you ever been affiliated with a gang or involved in gang-related activity, including while serving a prison term?
☐ Yes ☐ No

Family Background:

Please fill out the table below listing all family members, including parents, step-parents, brothers, step-brothers, sisters, step-sisters, spouse (maiden name), boyfriend, or girlfriend. Please give their current address.

Relationship	Name	Age	Address	Phone
Mother				
Father				
Sister(s)				
Brother(s)				
Step-mother				
Step-father				
Step/half sister				
Step/half brother				
Boy/girlfriend				

Have you ever been married? ☐ Yes ☐ No

If yes:

Name of Spouse (including maiden name)	Age when you married	Date of marriage	If divorced – what year	# of children

Please list each of your children and whether or not you have custody of each child. If you do not have custody of the child, please identify who does.

Relationship	Child's Name	Date of Birth	Age	Custody
Son(s)				
Daughter(s)				

Education Information:

Highest level of education completed: _____

Are you attending school? ☐ Yes ☐ No

If yes, please list the name of your school: _____

Substance Use Information:

Complete the table below with your substance use history:

Substance	Age first used	Date of last use	Frequency of Use	Daily use history	Quantity Typically Used	Method of use
Alcohol				☐ Yes ☐ No		
Marijuana				☐ Yes ☐ No		
Cocaine				☐ Yes ☐ No		
Heroin				☐ Yes ☐ No		

Opiate/Opioid Pain Pills (Vicodin, Percocet, OxyContin, Opana, etc.)				☐ Yes ☐ No		
Suboxone				☐ Yes ☐ No		
Methadone				☐ Yes ☐ No		
Amphetamine/Rx Stimulant Meds (Adderall, Ritalin, etc.)				☐ Yes ☐ No		
Methamphetamine				☐ Yes ☐ No		
Benzodiazepines (Xanax, Valium, Klonopin, etc.)				☐ Yes ☐ No		
Ecstasy/MDMA				☐ Yes ☐ No		
Inhalants				☐ Yes ☐ No		
Hallucinogens (LSD, PCP, acid, psilocybin, peyote, etc.)				☐ Yes ☐ No		
Over-the-counter Medication (DXM/Robitussin, codeine cough syrup, diet pills, etc)				☐ Yes ☐ No		
Other:				☐ Yes ☐ No		

List substances in order by **drug of choice**:

1. _____ 2. _____

3. _____ 4. _____

Have you ever experienced blackouts from drug/alcohol use? ☐ Yes ☐ No

If yes, when and from which substance: _____

Have you ever experienced withdrawal symptoms? ☐ Yes ☐ No

If yes, when and from which substance(s): _____

Have you had legal problems due to alcohol/drugs? ☐ Yes ☐ No

If yes, when and for what charge(s): _____

_____

Have you tried to quit using alcohol and/or drugs, but found it difficult? ☐ Yes ☐ No

Does your personality change when using alcohol or drugs? ☐ Yes ☐ No

If so, in what manner? _____

What problems have you experienced as a result of your substance use? _____

_____

_____

Do you have any alcohol/drug-free peers? ☐ Yes ☐ No

Do you have a problem with alcohol and/or drug use? ☐ Yes ☐ No

If yes, are you willing to reside at Certified Recovery Housing if deemed appropriate? ☐ Yes ☐ No

If yes, are you willing to receive treatment in a residential treatment facility? ☐ Yes ☐ No

If yes, are you willing to successfully complete a Community Based Treatment Facility? ☐ Yes ☐ No

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Treatment History:

Have you previously been court-ordered to attend substance use treatment or mental health treatment, but failed to do so?
☐ Yes ☐ No

Are you currently receiving any substance use treatment or mental health treatment? ☐ Yes ☐ No

If yes, who do you receive treatment from?_____

Have you participated in any of the programs listed below?

☐ Yes ☐ No **Bayshore Counseling Services**

Month and year attended: _____

Counselor's name: _____

Successful completion? ☐ Yes ☐ No

☐ Yes ☐ No **Firelands Counseling and Recovery Services (Formally Giving Tree)**

Month and year attended: _____

Counselor's name: _____

Successful completion? ☐ Yes ☐ No

☐ Yes ☐ No **Tabby Mowel – Sheriff's Office Mental Health Coordinator**

Month and year attended: _____

☐ Yes ☐ No **Group Recovery Meetings, such as AA, NA, SMART Recovery, etc.**

Months and years attended: _____

Voluntary or Involuntary attendance? _____

☐ Yes ☐ No **Inpatient/Residential program**

Name of Facility: _____

Name of Counselor: _____

Month and year attended: _____

Successful completion? ☐ Yes ☐ No

☐ Yes ☐ No **Outpatient program:**

Name of Facility: _____

Name of Counselor: _____

Month and year attended: _____

Successful completion? ☐ Yes ☐ No

Mental Health:

Have you ever been diagnosed with a mental illness? ☐ Yes ☐ No

If yes, when, by whom, and what was the diagnosis/diagnoses: _____

_____

_____

Has anyone in your family been diagnosed with a mental illness? ☐ Yes ☐ No

If yes, who, and what was the diagnosis/diagnoses: _____

_____

Are you on any mental health medications (antidepressants, mood stabilizers, etc)? ☐ Yes ☐ No

If yes, name of drug(s), dosage, and how long you have been taking it: _____

_____

_____

Have you ever been physically or sexually abused? ☐ Yes ☐ No

If yes, by whom, how old were you, and specify whether sexual or physical: _____

_____

Have you ever attempted suicide? ☐ Yes ☐ No

If so, please list where and when you received any medical treatment, psychiatric treatment, or were hospitalized: _____

How do you typically deal with anger? _____

How do you typically deal with disagreements? _____

Physical Health:

Do you have any current physical health problems? ☐ Yes ☐ No

If yes, please list: _____

Are you taking any physical health medications? ☐ Yes ☐ No

If yes, name of drug(s): _____

Do you have any physical health disabilities? ☐ Yes ☐ No

If yes, please list: _____

Would your physical health disability interfere with your ability to attend treatment? ☐ Yes ☐ No ☐ N/A

If yes, in what way? _____

_____

_____

Do you have medical insurance (including Medicaid)? ☐ Yes ☐ No

Insurance Provider: _____

List any insurance you have had in the past: _____

_____

_____

Financial:

Work Status: ☐ Full Time ☐ Part Time: _____(hours/week) ☐ Unemployed

Hourly Rate: $_____ Work Schedule: _____

Employer Name:_____ Employer Phone: _____

Position(s) held: _____ Hire Date: _____

If you and/or your household are receiving any of the benefits listed below, please check all that apply, and list the monthly amount received:

Disability (SSI/SSDI):	☐ Yes ☐ No Amount: $_____	☐ Self	☐ Household Member
Food Stamps:	☐ Yes ☐ No Amount: $_____	☐ Self	☐ Household Member
Cash Assistance:	☐ Yes ☐ No Amount: $_____	☐ Self	☐ Household Member
Unemployment:	☐ Yes ☐ No Amount: $_____	☐ Self	☐ Household Member

What are some of your goals? _____

_____

_____

_____

_____

Why do you think a treatment based court can help you? _____

_____

_____

_____

Which treatment court do you believe would be most appropriate for you? Please explain.

☐ Mental Health Court ☐ Drug Court ☐ Unsure

Please provide any other important information about your current situation:

Applicant's signature: _____ **Date:** _____

Ottawa County Court of Common Pleas
Mental Health Court Program
Drug Addiction Treatment Alliance Program
315 Madison Street Port Clinton Ohio, 43452
Phone: 419-734-7551/7552 Fax: 419-734-6852

Mental Health Court Coordinator	**Judge**	**DATA Coordinator**
Jaimee Prieur	Bruce Winters	Leah Brookins

Specialized Docket Release of Confidential Information

Name: _____ SSN: _____

Date of Birth: _____ Phone Number: _____

Address: _____

I, the undersigned, hereby grant permission for the Ottawa County Specialized Docket Courts (MHC and DATA) to obtain any and all information contained in my record (including information concerning testing, diagnosis or treatment of HIV/AIDS, psychiatric and/or drug/alcohol treatment, and/or sexual assault), for the purposes of my application and participation in the Specialized Docket Court, including the following:

- ☑ Any medical/dental/mental health/substance use diagnoses, assessment, evaluation, prescriptions, treatment, counseling, notes, charts, and prognosis.
- ☑ Any employment records, dates of hire, rates of pay, dates of termination, type of termination, evaluations, schedule, attendance, and disciplinary actions.
- ☑ Any school transcripts, grades, attendance records, evaluation, assessment, IEP, and any disciplinary reports.
- ☑ Any housing records including evictions, debts, past residences held; to include recovery housing for referral and coordination purposes
- ☑ Any adult or juvenile criminal record, indictment, charges, presentence report, probation/parole report, urinalysis/breath test result, violation proceeding, or supervision notes.

Photographic reproductions of this form are to be given the same legal consideration as the original.

I understand that information disclosed by this authorization, except as prohibited by 42 CFR Part 2 or other applicable law, may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164].

This release shall terminate 180 days past completion of the Ottawa County Mental Health Court (MHC) or Drug Addiction Treatment Alliance (DATA) Program, 180 days past termination from MHC or DATA Program, or 180 days past denied entry into the MHC or DATA Program.

I have read and understand the nature of this release.

Signature:_____ □ legal guardian Date:_____

Witness Signature (mandatory):_____

Printed Name/Title of Witness (mandatory):_____