

STATE OF MICHIGAN COUNTY OF JACKSON 4 <sup>th</sup> JUDICIAL CIRCUIT 12 <sup>TH</sup> JUDICIAL DISTRICT	JACKSON COUNTY MENTAL HEALTH COURT ELIGIBILITY APPLICATION	Circuit Court Case No:
		District Court Case No:
		Judge

PEOPLE OF THE STATE OF MICHIGAN	V	Defendant:
		Defense Counsel

Attorney/ Defendant: Complete the application and sign /date on page three. Mail or fax to Carrie Dashner,; Fax # 517-784-7040 and address is 1200 North West Avenue Suite 300, Jackson, MI 49202

Address:	DOB:	Age:	Social Security Number:
	Home Phone:		Work Phone:
Candidate is: <input type="checkbox"/> Incarcerated <input type="checkbox"/> On bond			
Charge leading to Mental Health Court Referral:		Felony Sentence Guidelines:	
Has Participant been on probation before <input type="checkbox"/> Yes <input type="checkbox"/> No      Successfully Completed <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, where? _____			
Pending Case (s) in –non Jackson Courts? <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes please describe:			
Describe any pending local charge(s):			

**Family Background:**

Single                       Married  
 Divorced                       Separated  
 Widowed                       Other

Names, Dates of Birth and addresses of children: \_\_\_\_\_  
\_\_\_\_\_

**Custody Status of Children:**

Never lost custody: \_\_\_\_\_  
Temporarily lost custody: \_\_\_\_\_  
Parental rights terminated: \_\_\_\_\_  
Not applicable: \_\_\_\_\_

**Contact Information:**

Name, address, and telephone number of emergency contact individual: \_\_\_\_\_  
\_\_\_\_\_

State your relationship with the contact person. i.e. spouse, sibling, friend, etc. \_\_\_\_\_

**Offender/ Criminal History:**

Charge	Date of Conviction	Court

Did you have or possess a weapon or have a weapon in your control at the time of your arrest for the pending charge? \_\_\_ Yes  
\_\_\_ No If yes, please explain: \_\_\_\_\_

\_\_\_\_\_  
(Required information, not used for disqualification)

**RACIAL/ETHNIC BACKGROUND:**

**GENDER**

Check all that apply:

- |   |  |                                 |
|---|--|---------------------------------|
| <input type="checkbox"/> African American       | <input type="checkbox"/> Hispanic        | <input type="checkbox"/> Male   |
| <input type="checkbox"/> Alaskan Native         | <input type="checkbox"/> Native American | <input type="checkbox"/> Female |
| <input type="checkbox"/> Asian/Pacific Islander | <input type="checkbox"/> Other           |                                 |
| <input type="checkbox"/> Caucasian              |  |                                 |

**EDUCATIONAL STATUS:**

- No high school degree or GED
- High school degree or GED
- Some college/post high school
- College degree
- Post college degree

**EMPLOYMENT HISTORY:**

Are you currently employed? \_\_\_ Yes \_\_\_ No

State the name and address of the employer along with job title and duration of employment: \_\_\_\_\_

\_\_\_\_\_  
Excluding the employer listed above, please provide the names and addresses of your three most recent employers with periods of employment for each and reasons for ending employment: \_\_\_\_\_

\_\_\_\_\_  
**MEDICAL:**

Do you have any current medical conditions including those involving psychiatric and/ or psychological diagnoses?

\_\_\_ Yes \_\_\_ No If yes, describe: \_\_\_\_\_

\_\_\_\_\_  
Are you on any medications? \_\_\_ Yes \_\_\_ No If yes, describe: \_\_\_\_\_

For each medication listed please identify prescribing physician: \_\_\_\_\_

\_\_\_\_\_  
Please list the names and addresses of all mental health care providers that you have seen in the last five years: \_\_\_\_\_

\_\_\_\_\_  
Have you ever had any inpatient mental health hospitalization? \_\_\_ Yes \_\_\_ No If yes, please provide the following:

Hospital	Address	Date of Hospitalization

**Substance Abuse History:**

Prior substance abuse?  Yes  No

Drug of Choice? \_\_\_\_\_

Prior substance abuse treatment?  Yes  No

If yes, please describe the program (s) / treatment rendered and the duration of the treatment: \_\_\_\_\_

\_\_\_\_\_

**Alcohol Use:**

Years using alcohol? \_\_\_\_\_

Amount consumed weekly/ daily: \_\_\_\_\_

Have you ever received alcohol abuse treatment?  Yes  No

If yes, please describe the treatment and dates of the same. Additionally identify the treating health providers:

\_\_\_\_\_

**Insurance:**

Do you have Medicaid coverage?  Yes  No

What is your Id number? \_\_\_\_\_

\_\_\_\_\_  
Defendant's Signature

\_\_\_\_\_  
Defense Counsel

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

**NOTICE**

Upon receipt of application by Program, candidate will be contacted within 48 hours to schedule intake screening.