VETERANS TREATMENT COURT
DEFENSE ATTORNEY CHECKLIST

REFERRAL GUIDELINES

The Tarrant County Veterans Treatment Court (VTC) is an 8-24 month diversion program for Justice- Involved Veterans (JIVs) who are currently facing prosecution for one or more criminal cases. The goals are to find JIVs, assess their needs, offer assistance, manage their care and provide them with successful treatment options ultimately leading to community reintegration, and resolution of their criminal case(s).

Please return this completed checklist with all required documents to expedite application for admission into the VTC. All documents can be scanned and emailed, faxed, mailed or delivered to:

ADDRESS	***FAX***	***EMAIL***
Tarrant County Veterans Treatment Court ATTN: Rocio Lopez 300 W. Belknap 4th Floor Fort Worth TX 76196 817-884-3225	817-850-8960	VeteransCourt@tarrantcountytx.gov

VETERAN INFORMATION

DEFENDANT NAME: _____ CID: _____

CASE #(S): _____ OFFENSE(S): _____

_____ _____

_____ _____

_____ _____

ATTORNEY NAME: _____ DATE OF REFERRAL: _____

CHECKLIST

Check all documents that are attached:

☐ VTC Defense Attorney Checklist

☐ VTC Information Sheet (Provided by VTC Staff)

☐ DD214 (Certificate of Release or Discharge from Active Duty) or National Guard Report of Separation (Form NGB-22)

☐ Signed VA Release of Information Form 10-5345 and VA Form 3288 *(Provided by VTC Staff)*

☐ Mental Health Psychiatric Evaluation or Mental Health Assessment

ATTORNEY ACKNOWLEDGEMENT

By signing below, you acknowledge you have discussed the Veterans Treatment Court with your client and you both agree admission into the VTC is in the best interest of your client. You acknowledge that any and all information received by the VTC will be made available to the Tarrant County District Attorney's Office and final approval for admission will be determined by a representative of the District Attorney's Office.

ATTORNEY SIGNATURE: _____ DATE: _____

TARRANT COUNTY VETERANS TREATRMENT COURT
INFORMATION SHEET

Veteran's Name: _____ **DATE: _____**

DEMOGRAPHIC INFORMATION:

Street Address: _____ City: _____ State: _____ Zip: _____
DOB: _____ Age _____ Sex: _____ Race: _____ Ethnicity: _____
Mobile#: _____ Home#: _____Email: _____

CRIMINAL HISTORY:

Tarrant County CID#: _____DPS#: _____SID#: _____
Current Offense(s): _____ Case#: _____County/Court: _____
_____ Case#: _____County/Court: _____
_____ Case#: _____County/Court: _____
Currently on Probation or Parole? Yes ☐ No ☐
In Jail: Yes ☐ No ☐ If "No", were you released on a Personal Bond: Yes ☐ No ☐
If DWI Offense(s), was there a crash or damage to any property: Yes ☐ No☐
List Prior Offenses: _____

MILITARY INFORMATION:

Branch of Service: _____ Service Dates: _____ Rank: _____
Active Duty: ☐ Reserves:☐ National Guard: ☐ State Guard: ☐ Retired: ☐
Deployment(s) Locations and Dates: _____
Type of Discharge: Honorable ☐ General ☐ OTH ☐ Bad Conduct ☐ Dishonorable ☐

MENTAL HEALTH INFORMATION:

Eligible for Healthcare at the VA: Yes ☐ No ☐ Enrolled in the VA Healthcare System: Yes ☐ No ☐
Are you receiving Mental Health Treatment: Yes ☐ No ☐
Mental Health Diagnoses: _____
Treatment Provider Name: _____ Phone: _____
Medications: _____

SUBSTANCE USE HISTORY (Check all that Apply):

THC ☐ Cocaine ☐ PCP ☐ Prescription RX ☐ Opiates ☐ Alcohol ☐ Fentanyl ☐ Methamphetamines ☐
Other ☐ (Please list): _____

ATTORNEY INFORMATION:

Attorney Name: _____ Attorney Phone#: _____
Attorney Fax #: _____ Attorney Email: _____

Referred by: _____

Form Approved: OMB No. 2900-0028
Respondent Burden: 7.5 minutes

Department of Veterans Affairs

REQUEST FOR AND CONSENT TO RELEASE OF INFORMATION FROM INDIVIDUAL'S RECORDS

PRIVACY ACT STATEMENT: The execution of this form does not authorize the release of information other than that specifically described below. The information requested on this form is solicited under Title 38, United States Code, and will authorize release of the information you specify. The information may also be disclosed outside VA as permitted by law to include disclosure as stated in the "Notices of Systems of VA Records" published in the Federal Register in accordance with the Privacy Act of 1974.

RESPONDENT BURDEN: VA may not conduct or sponsor, and the respondent is not required to respond, to this collection of information unless it displays a valid OMB Control Number. The Privacy Act of 1974 (5 U.S.C. 552a) and VA's confidentiality statute (38 U.S.C. 5701) as implemented by 38 CFR 1.526(a) and 38 CFR 1.576(b) require individuals to provide written consent before documents or information can be disclosed to third parties not allowed to receive records or information under any other provision of law. The information requested is approved under OMB Control Number 2900-0028 and is necessary to ensure that the statutory requirements of the Privacy Act and VA's confidentiality statute are met.

Responding to this collection of information is voluntary. However, if the information is not furnished, we may not be able to comply with your request. Public reporting burden for this collection is estimated to average 7.5 minutes per respondent, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspects of this collection of Information, including suggestions for reducing this burden, to the VA Clearance Officer (005E3), 810 Vermont Avenue, NW, Washington, DC 20420. **Send comments only. Do not send** this form or requests for benefits to this address.

TO	Department of Veterans Affairs VA Waco Regional Office (349) 701 Clay Ave. Waco, Texas 76799	NAME OF INDIVIDUAL *(Type or print)*	
		VA FILE NO. *(Include prefix)*	SOCIAL SECURITY NUMBER

NAME AND ADDRESS OF ORGANIZATION OR INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

Tarrant County Veterans' Treatment Court(VTC), 300 W. Belknap 4th Floor FTW, TX 76196. All affiliated individuals, agencies, VHA, attorneys, court evaluator, and other court staff. Veteran agrees to additional guests as permitted by Judges' authorization

_____ INITIAL HERE

VETERAN'S REQUEST

I hereby request and authorize the Department of Veterans Affairs to release the following information from the records identified above to the organization, agency, or individual named hereon: ▶

NAME

Tarrant County Veterans Treatment Court

INFORMATION REQUESTED *(Number each item requested and give the dates or approximate dates - period from and to - covered by each.)*

VBA will provide summary of progress via written, verbal, telephonic, fax, and/or secured email that is required by the court for monitoring of Veteran benefits/claims progress and compliance. Data will be inclusive of relevant benefit information, but not to be limited to: Veteran eligibility verification, DD214, service connected compensation, military service, CAPRI, service connected compensation, military service, CAPRI, social security benefit information, and any other Veteran benefit related information relevant to court/legal circumstances. Information will be shared at regular intervals, as needed by the court team to adequately assess Veteran progress and compliance with Veterans Treatment Court guidelines. Veteran Benefits record information is subject to review in open court.

EXPIRATION: (1) Upon VTC completion (2) Written revocation submitted to VA staff

_____ INITIAL HERE

PURPOSE(S) FOR WHICH THE INFORMATION IS TO BE USED.

To ensure the Veteran meets the required eligibility criteria for participation in the VTC and to assist with adhering to the VTC guidelines.

NOTE: *Additional information may be listed on the reverse side of this form.*

SIGNATURE OF INDIVIDUAL OR PERSON AUTHORIZED TO SIGN FOR INDIVIDUAL *(Attach authority to sign, e.g., POA)*	DATE

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

PRIVACY ACT AND PAPER WORK REDUCTION ACT INFORMATION: The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Act. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless is displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 2 minutes. This includes the time it will take to read the instructions, gather the necessary facts and fill out this form. The execution of this form does not authorize the release of information other than that specifically described below.

The information requested on this form is solicited under Title 38 U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164; 5 U.S.C. 552a; and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if information needed to locate records for release is not furnished completely and accurately, VA will be unable to comply with the request. The Veterans Health Administration may not condition the provision of treatment, payment, enrollment in the VA Health Care Program, or eligibility for benefits on the signing of an authorization, except for research-related treatment where an authorization for the use or disclosure of individually-identifiable health information for such research is required. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act system of records notices identified as 24VA10A7 "Patient Medical Record - VA", 08VA05 "Employee Medical File System Records (Title 38)-VA" and in accordance with the Notice of Privacy Practices. VA may also use this information to identify Veterans and person claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

TO: DEPARTMENT OF VETERANS AFFAIRS *(Name and Address of VA Health Care Facility)*

VA North Texas Health Care System, 4500 S. Lancaster, Dallas, TX 75216 and any other VHA hospital system (including Vet Centers) where the Veteran has or will receive services.

LAST NAME- FIRST NAME- MIDDLE NAME	DATE OF BIRTH *(mm/dd/yyyy)*
LAST 4 SSN:	

PATIENT'S MAILING ADDRESS (*including City, State and Zip Code*)

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL, OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

Tarrant County Veterans' Treatment Court (VTC), 300 W. Belknap 4th Floor FTW, TX 76196. All affiliated individuals, agencies, VBA, attorneys, court evaluator and other court staff. Veteran agrees to additional guests as permitted by Judges' authorization.

_____ INITIAL HERE

PURPOSE(S) OR NEED: Information is to be used by the requestor for:

☒ TREATMENT ☒ BENEFITS ☒ LEGAL ☐ EMPLOYMENT ☐ OTHER *(Please specify)* _____

INFORMATION REQUESTED: Check applicable box(es) and state the extent or nature of information to be provided:

☐ HEALTH SUMMARY *(Prior 2 Years)*

☐ INPATIENT DISCHARGE SUMMARY *(Dates)*: _____

☒ PROGRESS NOTES:

- ☒ SPECIFIC CLINICS *(Name & Date Range)*: Mental health, Medical, & Substance abuse notes
- ☐ SPECIFIC PROVIDERS *(Name & Date Range)*: _____
- ☐ DATE RANGE: _____

☐ OPERATIVE/CLINICAL PROCEDURES *(Name & Date)*: _____

☒ LAB RESULTS:

- ☒ SPECIFIC TESTS *(Name & Date)*: Drug utox screens past & future deemed relevant by court.
- ☐ DATE RANGE: _____

☐ RADIOLOGY REPORTS *(Name & Date)*: _____

☒ LIST OF ACTIVE MEDICATIONS: _____

☐ FLU VACCINATION *(Dose, Lot Number, Date & Location)*: _____

☒ OTHER *(Describe)*: All relevant appts, MH & Medical info, DD214 & VBA info needed for court

LAST NAME- FIRST NAME- MIDDLE NAME	DATE OF BIRTH *(mm/dd/yyyy)*
LAST 4 SSN:	

SENSITIVE DIAGNOSES: REVIEW AND, IF APPROPRIATE, COMPLETE WHEN RELEASE IS FOR ANY PURPOSE OTHER THAN TREATMENT.

I request and authorize Department of Veterans Affairs to release the information pertaining to the condition(s) below for the non-treatment purpose(s) listed in this authorization. ***_____ INITIAL HERE

☐ DRUG ABUSE ☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ SICKLE CELL ANEMIA

☐ HUMAN IMMUNODEFICIENCY VIRUS *(HIV)*

I understand that information on these sensitive diagnoses may be released for treatment purposes without me checking the above boxes, and will be released even if the boxes are unchecked unless I indicate by checking the box below that I do not want this information released for this specific disclosure.

☐ **I do not want sensitive diagnoses released for treatment purposes under this specific authorization. I realize this does not impact other future requests unrelated to this authorization.**

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing records. Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

I understand that the VA health care provider's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions.

EXPIRATION: Without my express revocation, the authorization will automatically expire *(select one of the following)*:

☐ AFTER ONE-TIME DISCLOSURE, IF ALL NEEDS ARE SATISFIED

☐ ON *(mm/dd/yyyy)* _____ *(enter a future date other than date signed by patient)*

☒ UNDER THE FOLLOWING CONDITION(S): 1.Written revocation submitted to VA staff. 2.Written verification from court that VA recs are no longer required. 3.Upon court completion.

PATIENT SIGNATURE *(Sign in ink)*	DATE *(mm/dd/yyyy)*
LEGAL REPRESENTATIVE SIGNATURE (*if applicable*) *(Sign in ink)*	DATE *(mm/dd/yyyy)*
PRINT NAME OF LEGAL REPRESENTATIVE	RELATIONSHIP TO PATIENT

FOR VA USE ONLY

TYPE AND EXTENT OF MATERIAL RELEASED

VJO/VA providers will provide summary of progress via written, verbal, telephonic, fax, and/or secured email that is required by the court for monitoring of Veteran treatment progress and compliance. Data will be inclusive of all relevant medical record information, but not to be limited to: diagnoses (medical, mental health, & substance abuse), relevant labs, progress in treatment programming, developmental, social, financial, & military data relevant to court/legal circumstances. Information will be shared at regular intervals, as needed by the court team to adequately assess progress of Veteran and compliance with court guidelines. Medical record information is subject to review in open court.

DATE RELEASED *(mm/dd/yyyy)*	RELEASED BY: