OFFICE OF THE WASHINGTON COUNTY ATTORNEY
PETER J. ORPUT COUNTY ATTORNEY

APPLICATION TO BE SCREENED FOR PARTICIPATION IN THE WASHINGTON COUNTY ATTORNEY'S OFFICE VETERANS PROGRAM

The Washington County Attorney's Office operates a Veterans Program (VP) to handle certain presumptive probation cases in which the defendant is a veteran struggling with the effects of his or her service in a hostile area.

The VP is built upon a unique partnership between the criminal justice system, the Department of Veterans Affairs (VA), and local providers. These partners structure treatment and support intervention with the authority and personal involvement of the prosecuting authority.

ALL APPLICANTS MUST COMPLETE THE FOLLOWING SCREENING QUESTIONS AND SUBMIT A COPY OF THEIR DD214 ALONG WITH THE ATTACHED AUTHORIZATIONS TO DISCLOSE PRIVATE DATA:

1. Name: _____
2. Date of Birth: _____
3. Address: _____
4. Phone: _____
5. Branch of Service: _____
6. Rank & Grade: _____
7. Military Job Title: _____
8. Dates of Service: _____

9. All Duty Stations: _____

10. Type of Discharge: _____

11. Please explain why you want to be involved in the veterans program:

_____

_____

_____

Eligibility Criteria

- Defendant must have served in the United States Armed Services and generally be eligible for VA benefits or alternative treatment services.
- Except in very rare instances, defendant must be charged with a crime that carries a presumptive probation sentence.
- Defendant must not be maintaining his innocence.
- Admittance into the program is at the sole discretion of the County Attorney.

Factors for Participation

- Whether the defendant is experiencing treatable behavioral and chemical or mental health issues, i.e., post-traumatic stress disorder, traumatic brain injury, anger management, domestic violence, and/or substance abuse or chemical dependency.
- Whether, and the extent to which, the defendant's conduct surrounding or leading to the offense is related to the effects of defendant's military service.
- Whether programming and services available through the Veteran's Administration and the monitoring and mentoring through the VP will assist in probation supervision.

Assessed at the VA

- The application process includes meeting with Marianne Hamrick, (612) 313-3274, Veterans Justice Outreach Specialist at the VA Medical Center.

Data Notice

You are being requested to provide certain data about yourself to the Washington County Attorney's Office. Some of this data may be classified as private data under the Minnesota Government Data Practices Act. Data gathered through telephone contacts or written correspondence with VP staff may be shared with court service agencies, law enforcement or criminal justice system agencies, veteran affairs agencies and your authorized representative. You are not required to provide the requested information, however, failure to do so will prevent you from participating in the VP.

Release of Information

Each participant in the Washington County Attorney's Office VP must permit medical and alcohol/drug treatment providers to furnish information, including mental health, relating to the participant's treatment to any member of the Program for the duration of the Program. Each participant must also consent to release medical, mental health, criminal, employment, and educational records to the Program to determine eligibility for the Program, to determine the proper treatment placements and regiment, and to judge progress in the Program. Each participant must submit the attached forms with the application and update the forms as necessary. Failure to submit the forms will result in rejection from the Program.

Request to Participate

I, _____, hereby request to be screened for participation in the Washington County Attorney's Office VP. I understand that to be eligible for consideration I must meet the eligibility criteria and agree to comply with all terms and conditions of the program.

Signed: _____ Dated: _____

Submit form to: Brent Wartner, Veterans Program Coordinator

Washington County Attorney's Office

15015 62nd Street North, P.O. Box 6

Stillwater, MN 55082-0006

STATE OF MINNESOTA **DISTRICT COURT**
COUNTY OF WASHINGTON **TENTH JUDICIAL DISTRICT**

State of Minnesota Case # 82-CR-_____
v.

_____

CONSENT TO RELEASE PRIVATE HEALTH, ALCOHOL/DRUG AND MENTAL HEALTH RECORDS AND INFORMATION

My full name is _____ My date of birth is _____

1. I understand that to be considered for participation in the Washington County Attorney's Office Veterans Program (Program) I must allow my medical and alcohol/drug treatment providers to furnish information, including mental health, relating to my treatment to any member of the Program for the duration of my participation in the Program, and by signing this agreement I agree to the disclosure of such records and information.

2. I understand that my treatment records are protected under the federal law and regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and 38 U.S.C. 7332, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that my medical records are protected by federal law and regulations. I also understand that my records concerning mental health services I receive are protected by state law. I understand that I may revoke this authorization at any time with a written request, and by doing so, I am choosing to opt out of the Program. **Otherwise, this consent will expire twenty-four months from the date listed below.** I further understand that my records may be transmitted by fax and electronically.

3. I understand that the purpose of releasing this medical and treatment information is for the Program to determine my eligibility for the Program, to determine the proper treatment placements and regiment, and to judge my progress in the Program.

4. I understand that my medical and treatment information may be discussed in the Program where other participants and observers may hear it.

5. I have read this document, or it has been read to me, and I understand its contents. By signing this Consent, I am telling the Court that I understand the rights I am waiving.

DATE _____ _____
Veteran Defendant

DATE _____ _____
Veteran Defendant's Attorney

Authorization to Disclose
Claimant/Benefit and Protected Health Information

The Washington County Attorney's Office Veterans Program has made it a condition of my participation in its disposition of my pending criminal matters that I disclose information protected by 5 U.S.C. 552a, 38 U.S.C. 5701, 45 CFR Parts 160 and 164, and 38 USC §7332 (drug and alcohol abuse, HIV infection, and sickle cell anemia) to the criminal justice system.

Therefore, I, _____, request that the United States department of
(Veteran's Name)
Veterans Affairs, Veterans Benefits Administration, and Veterans Health Administration disclose my claimant and/or benefit information and protected health information to the following:

The Washington County Attorney's Office and all parties sanctioned by and associated with its Veterans Program in either pre or post court proceedings. _____

I authorize release of the following protected health information:

Any and/or all claimant and/or benefit information and any and/or all medical and psychological information to include communication in person, by telephone, mail, encrypted email, or fax.

I certify that this request is made freely, voluntarily and without coercion and that the information on this form 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 understand that the VA may not condition treatment, payment, enrollment, or eligibility for benefits upon my signing of this authorization.

This authorization will expire upon discharge from the Washington County Attorney's Office Veterans Program. I understand that I may not revoke this authorization before that date. I understand that failure to provide the Veterans Program with the appropriate authorizations may lead to my removal from the Veterans Program venue and the transfer of my pending criminal matters to the regular District Court venue.

_____ _____

Date Print Name and Last Four of SSN

_____

Signature

_____

Address