# Adult Redeploy Illinois Application Form

## Personal Information

**Last Name:_____First Name_____Middle Initial_____**

**Address:_____**

**City:_____ State:_____ Zip:_____ Phone#:_____**

**Date of Birth_____ Race_____ Gender: Male / Female**

**Social Security (last 4 digits) #_____Driver's License #_____**

**Marital Status: Married / Single / Divorced / Widow/er / Living as Married**

**Spouse Name_____Number of Children_____Pregnant? N/A / Yes/ No**

## Education

**Highest Grade Completed:_____ Current School:_____**
**Reading Problem: Yes / No Writing Problem: Yes / No Did you have an I.E.P.: Yes / No**

## Employment/Benefits

**Source of Income:_____Employer:_____**

**Occupation:_____ Insurance: Yes / No Company:_____**

**Group/ ID/Policy Number:_____**

**Social Security Benefits: Yes /No Medicare: Yes / No Medicaid: Yes /No Provider _____**

**Denied Benefits: Yes / No Reason:_____Date:_____**

**Benefits Stopped: Yes / No Reason:_____ Date:_____**

## Criminal History

**Current Charge:_____ Attorney:_____**

**Other Cases Pending:Yes/ No Out of County Case: Yes/No (If yes, list under comments)**

**Currently on Probation: Yes / No Officer_____ Parole: Yes / No Agent_____**

**Comments:**

_____

_____

# Mental Health/Medical

**Psychiatric Diagnosis:**_____

**Psychiatrist:**_____ **Address:**_____

**City:**_____ **State:**_____**Telephone Number:**_____

**Psychologist/ Other Clinician**_____**Address:**_____

**City:**_____ **State:**_____**Telephone Number:**_____

**Medication/Dosage**_____

**Medication/Dosage**_____

**Medication/Dosage**_____

**Have you ever been hospitalized for psychiatric reasons? Yes / No**

**Where:**_____**Dates:**_____

**Where:**_____**Dates:**_____

**Medical Issues Yes/ No Diagnosis**_____

**Medication/Dosage** _____

**Medication/Dosage** _____

# Substance Abuse

**Please List all Drugs you have experimented with**

**Drug:**_____ **Age of First Use**_____**Frequency**_____
**Drug:**_____ **Age of First Use**_____**Frequency**_____
**Drug:**_____ **Age of First Use**_____**Frequency**_____
**Drug:**_____ **Age of First Use**_____**Frequency**

**Signature:**_____ **Date:**_____

**Attorney Signature**_____**Date:**_____

**I acknowledge that my client is applying for Adult Redeploy Illinois Court.**
**Please Fill Out All Three Pages of This Form**

**12/2014**

WILL COUNTY ADULT REDEPLOY ILLINOIS COURT PROGRAM

CONSENT FOR DISCLOSURE OF CONFIDENTIAL MENTAL HEALTH INFORMATION & CONSENT FOR DRUG TESTING

ADULT REDEPLOY ILLINOIS (ARI) COURT REFERRAL

**I, _____, hereby consent to communication between the** Will County Adult Redeploy Illinois Court Program, the presiding Judge and the Adult Redeploy Illinois Court Team for the purpose of determining my eligibility and/or acceptability for Mental Health/Substance Abuse treatment services. I authorize the exchange of information, including all evaluations, test results, and treatment information between the ARI Court Team and my prior treatment providers, if any. I understand that my case, my history, prior treatment, treatment attendance, prognosis, and compliance will be discussed. The information released, however, may not be used by the prosecutor for the filing of further charges against me, nor may any information so released be used against me in the current proceedings.

Disclosure of this confidential information may be made only as necessary for, and pertinent to, hearings and/ or reports concerning my current charges.

I understand that by signing this form I am required to drug test as part of the application process and as compliance with my bond.

I understand that this consent will remain in effect and cannot be revoked by me until there has been a formal and effective termination of my involvement with the Will County Adult Redeploy Illinois program for the current charge(s). This includes, being declared unacceptable for the program, discontinuation of all court and/or probation supervision upon my successful completion of the drug court requirements OR upon sentencing for violating the terms of my drug court involvement.

I understand that any disclosure made is bound by Part 2 of Title 42 of the Code of Federal Regulations, which governs the confidentiality of substance abuse patient records and that recipients of this information may re-disclose it only in connection with their official duties.

_____ _____

Date Name

_____

Signature

_____

Signature of Defense Counsel