SUPERIOR COURT OF COBB COUNTY
VETERANS ACCOUNTABILITY AND TREATMENT COURT

APPLICATION INSTRUCTIONS

1. Review with the defendant the program eligibility requirements (**please see Judicial Council of Georgia's "Standard for Accountability Courts §2.3" concerning defense counsel)**. To participate in this program, the defendant must:
    a. Be a veteran of the United States armed forces.
    b. Face an issue of mental illness, post-traumatic stress disorder, or substance abuse.
    c. Be competent to enter a plea of guilty.
    d. Have, or be able to obtain, stable housing in Cobb County.

2. Complete and sign all documents included in this packet. If the case has been indicted or accused, ***you must include the Indictment/Accusation number on each applicable document.*** If the case has not been indicted or accused, you must include the warrant number. Do not include any other identifying numbers, such as the police complaint number.

3. File the "PETITION TO PARTICIPATE IN VETERANS ACCOUNTABILITY AND TREATMENT COURT" FORM WITH THE Clerk of Superior Court if the case has been indicted or accused. If there is no indictment or accusation, the petition may remain with this packet.

4. **Submit a copy of the Petition (or the original Petition if the case is not indicted or accused) along with all remaining documents to the District Attorney's Office (via regular mail or at our 3rd Floor Reception Desk) or email them to VetCourtApp@cobbcounty.org for further review.**

5. Upon notification of the defendant's acceptance into the program, be prepared to schedule defendant's plea submission.

    a. Those defendant's eligible to participate on a pre-adjudication basis will plead guilty but the Court will withhold sentence. Upon successful graduation, the Court will permit the defendant to withdraw the plea and will enter a Nolle Prosequi order.
    b. All other defendants will plead guilty, and the Court will impose a sentence with successful participation in this program as a special condition.

After thoroughly reading these instructions, if you have any questions, please call the District Attorney's Director of Accountability Courts at (770) 528-3080. This posted document may be amended or supplemented at any time in the discretion of the Veterans Court team. Therefore, a new packet must be obtained by visiting **www.cobbda.com** for each defendant. ***Copies should not be kept for future use.***

IN THE SUPERIOR COURT OF COBB COUNTY
VETERANS ACCOUNTABILITY AND TREATMENT COURT
STATE OF GEORGIA

THE STATE OF GEORGIA	§	CASE NO.
V.	§	_____
_____	§	

PETITION TO PARTICIPATE IN VETERANS ACCOUNTABILITY AND TREATMENT COURT

Comes now, _____, Defendant charged in the above styled case and shows the court the following:

The Defendant is charged with the offense of _____. The defendant is a veteran of the United States armed forces, and to the best of his or her knowledge and belief, is eligible for benefits through the United States Department of Veterans Affairs.

The Defendant has been advised of the requirements of the Cobb County Superior Court's Veterans Accountability and Treatment Court Program and is able and willing to meet all criteria necessary to enter said program.

The Defendant has been advised of his/her Constitutional Rights by the undersigned attorney, and understands the requirement to waive certain of these rights in order to enter the program. The Defendant further understands that, should he/she not be accepted in the Veterans Accountability and Treatment Court Program for any reason, the case will be returned to the normal criminal justice system.

Wherefore, Defendant prays that the Court allow this defendant's participation in said Veterans Accountability and Treatment Court Program.

_____ _____
Attorney for Defendant Print name

Address:

_____ Telephone No. (__) _____

_____ Fax No. (__) _____

_____ Email _____

IN THE SUPERIOR COURT OF COBB COUNTY
VETERANS ACCOUNTABILITY AND TREATMENT COURT
STATE OF GEORGIA

THE STATE OF GEORGIA	§	CASE NO.
V.	§	_____
_____	§	

VETERANS ACCOUNTABILITY AND TREATMENT COURT CONTRACT

I, _____, understand that the validity of this agreement is conditioned upon my eligibility for the Veterans Accountability and Treatment Court Program ("Veterans Court"). If at any time after the execution of this agreement it is discovered that I am ineligible to participate in the program, I may be immediately terminated from the program. In consideration of the agreement by the State to allow participation in this program in lieu of traditional prosecution of my charged offense(s), I hereby agree to the following (please initial each):

1. _____ I will complete each and every aspect of the Veterans Accountability and Treatment Court Program, which I understand involves a minimum time commitment of eighteen (18) months and which may be extended indefinitely due to treatment compliance or other factors.
2. _____ I understand that I may be required to complete mental health or substance abuse treatment based on my particular needs and diagnosis. I will cooperate in an assessment/evaluation for planning an individualized treatment program. I understand that my treatment plan may be modified by the treatment providers or the Veterans Court team as circumstances arise, and I agree to comply with the requirements of any such modifications.
3. _____ I will comply with the policies, procedures, and instructions of staff members of Veterans Court, including Department of Veterans Affairs or other treatment providers at any assigned treatment facility.
4. _____ I will be financially responsible for the costs associated with participation in Veterans Court as defined in my individual Participant Fee Contract, and will submit any financial disclosures required by the Veterans Court team.
5. _____ I will take any and all medication as prescribed by a physician or psychiatrist. I will report any difficulties taking medication (side effects, etc.) to the physician or psychiatrist immediately.
6. _____ I will keep the Veterans Court team advised of all medications I am prescribed, and will immediately report any change in status. I will execute any release necessary to allow said team to gain information about my medications from my physician, psychiatrist, or pharmacist.
7. _____ I will inform any physician, psychiatrist, or pharmacist from whom I seek any advice or treatment that I am a participant in Veterans Court.
8. _____ I will not possess, use, or ingest any drug, alcohol, or any substance which is designed to alter perception or mood, unless lawfully prescribed and approved by Veterans

Court staff, regardless of whether it is legal to possess or use such substance. I will not associate with people who use or possess such substances, nor will I knowingly be present while drugs, alcohol, or other such substances are being used by others.

9. _____ I will submit to testing for the presence of illegal or non-prescribed drugs, alcohol, and perception or mood altering substances in my system on a random basis according to procedures established by the Veterans Court team and/or treatment provider. I understand that I will be given a location and time to report for my drug test. I understand that it is my responsibility to report to the assigned location at the time given.
10. _____ I will not substitute, alter or try in any way to change my body fluids for purposes of testing.
11. _____ I will submit to a drug or alcohol test at any time, by any police officer, treatment provider, Veterans Court staff member, or at the direction of the Court or any agency designated by the Court.
12. _____ I will avoid persons and places of disreputable or harmful character or knowingly associating with persons who violate the law.
13. _____ I will not violate the laws of any governmental unit during my participation in this program.
14. _____ I will inform any law enforcement officer with whom I come in contact that I am a participant in Veterans Court and will immediately report to Veterans Court if I am arrested or issued a citation for any criminal offense by any law enforcement agency.
15. _____ I will not possess any weapons while I am in Veterans Court. I will dispose of any and all weapons in my possession, and disclose the presence of any weapons possessed by anyone else in my household.
16. _____ I will maintain a stable residence within Cobb County at all times during my participation in this program. I will keep the Veterans Court team advised of my current address, telephone number, and employment or school status, and will immediately report any change in status.
17. _____ I will not leave the State of Georgia at any time, or stay overnight at a location other than my approved residence, during the course of the program without the prior permission of the Veterans Court staff.
18. _____ I agree that if, in the reasonable opinion of a member of the Veterans Court team or a treatment provider, I exhibit behaviors indicating a risk of harm to myself or others, the proper authorities and my next of kin may be notified of such behavior. I hereby waive any right of confidentiality I may have in such information under such circumstances.
19. _____ I understand that any right I may have to request that my criminal history record be restricted (what is commonly known as "expungement") will be governed solely by O.C.G.A. §35-3-37, and that any request for such restriction must be filed in a separate proceeding. Nothing in this agreement shall guarantee any restriction on my criminal record, or limit my right to seek such restriction as allowed by law.
20. _____ I understand that this agreement is subject to future revisions, additions, and/or amendments, and that should my consent to such revision, addition, or amendment be required during my participation in this program, I will have the right to seek the advice of counsel.

I have read the above contract, or had it read to me, and I acknowledge that I understand all of its terms and conditions. **I understand that failure to comply with any of the conditions herein may result in a sanction up to and including termination from the program.** I have been given the opportunity to ask any questions which I may have. I hereby voluntarily enter into this agreement with the Cobb County Superior Court Veterans Accountability and Treatment Court Program.

Defendant's Signature	Date
Attorney for Defendant	Date
Assistant District Attorney	Date
Veterans Court Judge	Date

TO BE COMPLETED BY DEFENSE COUNSEL *(please initial each)*:

_____ I have explained the above information, along with the other application materials, to the defendant. I have explained the constitutional rights which the defendant hereby waives by submitting these materials.

_____ I believe that the defendant understands his/her constitutional rights and the consequences of entering this agreement.

_____ I believe (to the best of my professional knowledge and without rendering a medical opinion) that the defendant is competent to enter this agreement and does so freely and voluntarily.

SUPERIOR COURT OF COBB COUNTY
VETERANS ACCOUNTABILITY AND TREATMENT COURT

PROGRAM PARTICIPANT INFORMATION

Personal Information

Case Number _____ Date _____

Name _____ D.O.B. _____

Address _____
Street Apt# City State ZIP

County of Residence _____

Social Security # _____-_____-_____ Telephone (___)_____

Marital Status _____

Children (number and ages) _____

Contact in case of Emergency _____
Name Relationship

Telephone (Home) (___)_____ (Other) (___)_____

Employment

Employer _____

Address _____
Street Apt# City State ZIP

Telephone (___)_____ Immediate Supervisor _____

Medical Coverage Information

☐ Medicare ☐ Medicaid ☐ medication assistance (provide detail below)

Insurance _____

Other _____

SUPERIOR COURT OF COBB COUNTY
VETERANS ACCOUNTABILITY AND TREATMENT COURT

PROGRAM PARTICIPANT INFORMATION

Service Information

Defendant Name: _____ Case No.: _____

Branch of Service: _____

Years Active Duty: _____ From _____ to _____

Years Reserve: _____ From _____ to _____

Discharge: ☐ Honorable ☐ General ☐ Other than Honorable Conditions
☐ Bad Conduct ☐ Dishonorable ☐ Entry Level Separation

Overseas deployment(s) and dates: _____

_____

Combat Experience: ☐ Yes ☐ No

If yes, please give dates and locations: _____

_____

Applied for veterans benefits through Department of Veterans Affairs: ☐ Yes ☐ No

If yes, were benefits approved: ☐ Yes ☐ No

Received a Department of Veterans Affairs disability rating: ☐ Yes ☐ No

If yes, percentage of disability: _____%

SUPERIOR COURT OF COBB COUNTY
VETERANS ACCOUNTABILITY AND TREATMENT COURT

PROGRAM PARTICIPANT INFORMATION

References

Defendant Name _____ Case No. _____

Provide information for at least 2 people who Veterans Court staff may contact to verify the information contained in this application or to seek additional information. If Defendant will live with another person during participation in this program, that person must be included here.

Reference #1 _____
Name Relationship

Address _____
Street Apt# City State ZIP

Telephone (___)_____ If defendant lives with this person check here ☐

Reference #2 _____
Name Relationship

Address _____
Street Apt# City State ZIP

Telephone (___)_____ If defendant lives with this person check here ☐

Reference #3 _____
Name Relationship

Address _____
Street Apt# City State ZIP

Telephone (___)_____ If defendant lives with this person check here ☐

I hereby give permission for Drug Treatment Court staff members to contact the above individuals. I waive any right of confidentiality which may exist and I consent to these individuals discussing my living arrangements, mental health status, substance abuse, criminal charges, and any other information which may aid in assessing my eligibility for this program.

_____ _____
Defendant's Signature Date

SUPERIOR COURT OF COBB COUNTY
VETERANS ACCOUNTABILITY AND TREATMENT COURT

MEMORANDUM OF UNDERSTANDING CONCERNING ATTORNEY-CLIENT RELATIONSHIP IN VETERANS ACCOUNTABILITY AND TREATMENT COURT

I, _____, having requested to participate in the Cobb County Veterans Accountability and Treatment Court Program ("Veterans Court"), understand that decisions concerning the administration of this program are made by a multi-disciplinary team which may include program administrators, treatment providers, probation officers, Veterans Administration or Department of Defense officials, and attorneys representing both prosecution and defense, under the direction of the Veterans Court judge. While attorneys, including prosecutors, take part in this process, the program does not operate under the traditional adversarial model of other court proceedings. Because of this, I understand and agree to the following:

1. Prior to my acceptance into Veterans Court, I have the right to be represented by an attorney, either one chosen and retained by me or one appointed by the Cobb County Circuit Defender's Office. This attorney can advise me, among other things, as to whether Veterans Court is an appropriate and beneficial alternative to the traditional criminal litigation process in my particular case.

2. After my acceptance into Veterans Court, the administrator of the Cobb County Circuit Defender's Office, or his designee, will act as the defense representative on the Veterans Court Team. I will no longer have the right to have my previous attorney advise me regarding the decisions made by this team, including the imposition of sanctions where appropriate.

3. During my participation in this program, the defense representative will act not as my attorney in the traditional sense, but as a member of the Veterans Court team. As such, he or she will join in discussions and decisions regarding my participation in the program including, but not limited to, my advancement or non-advancement through the phases of the program and the imposition of sanctions for violations of the program's rules or contract.

4. The duties of the defense representative as a member of the Veterans Court team may not be in my best interest if I have violated any provision of Veterans Court's rules or contract.

5. I will not have the right to have an attorney represent me individually at court appearances during my participation in Veterans Court or before the Veterans Court team, even if the Court is considering whether to impose a sanction. Veterans Court proceedings are not "critical stages of litigation" and therefore I do not have a right

to be represented by an attorney during these proceedings. I understand that my case may be discussed, and sanctions (including incarceration) may be imposed, without my attorney or the prosecutor present.

6. Should the Veterans Court team decide to recommend that the Court terminate my participation in the program due to a violation or violations of the program's rules or contract, I will be entitled to be represented by an attorney, either one chosen and retained by me or one appointed by the Cobb County Circuit Defender's Office. This attorney may then represent me individually in termination proceedings and in any subsequent litigation involving the disposition of my case outside Veterans Court.

I have read this document or had it read to me and have been given the opportunity to ask any questions I may have. I have been given the opportunity to discuss this document with my attorney and have sought his or her advice as to whether Veterans Court would be beneficial for me, and I wish to be considered for participation in this program.

This the _____ day of _____, 20___.

_____ _____

Defendant Print Name

_____ _____

Attorney for Defendant Print Name

SUPERIOR COURT OF COBB COUNTY
VETERANS ACCOUNTABILITY AND TREATMENT COURT

CRIMINAL HISTORY CONSENT FORM

I hereby authorize the Cobb County Veterans Accountability and Treatment Court ("Veterans Court") and/or Cobb County Sheriff's Office to receive any criminal history record information pertaining to me which may be in the files of any criminal justice agency of any state, or any local criminal justice agency in the state of Georgia. This authorization shall be effective at any time during my participation in Veterans Court as well as at intervals of one, two, and five years after my completion of the program. I further give consent to the Veterans Court team to view my juvenile criminal history for the purpose of assessment only. I understand that such juvenile records cannot be used against me as an adult.

_____
Full name printed

_____
Address

_____ _____ _____
City State Zip Code

_____ _____ _____ _____
Sex Race DOB Social Security Number

_____ _____
Drivers' License Number State

_____
Participant's Signature

IN THE SUPERIOR COURT OF COBB COUNTY
VETERANS ACCOUNTABILITY AND TREATMENT COURT
STATE OF GEORGIA

THE STATE OF GEORGIA	§	CASE NO.
V.	§	_____
_____	§	

WAIVER OF RIGHT TO ASSERT SPECIFIED GROUNDS

AS A BASIS FOR MOTION OF RECUSAL

The defendant, and his or her counsel, hereby acknowledge that as consideration for acceptance and/or continued participation in the Cobb County Veterans Accountability and Treatment Court Program ("Veterans Court"):

1. That the above-styled case will be assigned to the Veterans Court division of Superior Court, and a designated elected, senior, or assisting Superior Court judge will sit as the Veterans Court judge;
2. That the Veterans Court judge will preside over any termination hearings, should consideration of termination arise prior to graduation; and
3. That should defendant fail to successfully complete Veterans Court and be terminated from said program, disposition of the case may be decided by the designated Veterans Court judge or may be referred to the previously-assigned judge.

Understanding that the assignment of this case may be to the designated Veterans Court judge throughout all proceedings until ultimate disposition of the case, irrespective of defendant's success or failure in completing Veterans Court, the defendant hereby waives his or her right to assent, as a basis for a motion to recuse the Veterans Court judge, any of the following:

1. The personal involvement of the Veterans Court judges with the defendant during his or her participation in Veterans Court;
2. The Veterans Court judges' knowledge, both personal and otherwise, of defendant's compliance or non-compliance with the requirements of Veterans Court; or
3. The Veterans Court judge's decision to terminate the defendant from Veterans Court on the basis of his or her failure to comply with such requirements.

Defendant hereby freely, voluntarily and knowingly waives the right to assert the foregoing as grounds for a motion to recuse and acknowledges that he or she does so having consulted with counsel.

This the _____ day of _____, 20___.

_____ _____

Defendant Attorney for Defendant

IN THE SUPERIOR COURT OF COBB COUNTY
VETERANS ACCOUNTABILITY AND TREATMENT COURT
STATE OF GEORGIA

THE STATE OF GEORGIA	§	CASE NO.
V.	§	_____
_____	§	

WAIVER OF RIGHTS

I, _____, understand that J am guaranteed by the United States and Georgia Constitutions the following rights:

1. A speedy trial;
2. A trial by jury;
3. The right to confront the witnesses against me;
4. The right not to incriminate myself or give any information which could be used against me;
5. The right to call witnesses and present evidence on my own behalf, and to use the power and process of the court to compel the attendance of such witnesses and evidence;
6. The right to have an attorney represent me at all stages of criminal process;

and that as a condition of acceptance into, and participation in, the Veterans Accountability and Treatment Court Program, I expressly waive (that is, give up) those rights.

I also understand that if I am not accepted in the program, my waiver of the rights listed above will also be withdrawn and I may petition the court for a speedy trial. Any statements given by me as part of the Veterans Court assessment process will not be used against me.

This the _____ day of _____, 20___.

_____ _____
Defendant Attorney for Defendant

IN THE SUPERIOR COURT OF COBB COUNTY
VETERANS ACCOUNTABILITY AND TREATMENT COURT
STATE OF GEORGIA

THE STATE OF GEORGIA	§	CASE NO.
V.	§	_____
_____	§	

WAIVER OF FOURTH AMENDMENT RIGHTS

I, _____, having requested to participate in the Cobb County Veterans Accountability and Treatment Court Program, and in consideration of the agreement by the State to allow such participation in lieu of traditional prosecution of my charged offense(s), hereby state the following:

I understand that I have rights that protect me from unreasonable search and seizure.

I understand that these rights are guaranteed by the Fourth Amendment to the United States Constitution, as well as the Constitution of the State of Georgia.

I also understand that I can voluntarily give up these rights as part of an agreement to provide an alternative to traditional prosecution or incarceration.

As a condition of my participation in this program, I agree to allow the search of my person, property, place of residence, vehicle or personal effects at any time with or without a warrant, and with or without reasonable cause, when required by a probation officer, treatment staff, Veterans Court staff, and/or any law enforcement officer at any time during my participation in this program. I hereby give permission for such individuals to remove, forcibly if necessary, any locks or other hindrances which may prevent access to such places and property for the purpose of any such search. I consent to the use of any evidence seized during such a search in any prosecution that may arise from said search.

This the _____ day of _____, 20___.

_____ _____
Defendant Attorney for Defendant

SUPERIOR COURT OF COBB COUNTY
VETERANS ACCOUNTABILITY AND TREATMENT COURT

DRUG SCREEN POLICY

I understand that if I test positive for drugs or alcohol at the time of my assessment, it will not be held against me because this screen is used to help determine eligibility for the Veterans Accountability and Treatment Court Program. However, I understand and agree that if I use drugs and/or alcohol at any time after the assessment, even prior to my acceptance or orientation into the program, I will receive a sanction which may include jail or termination from the program. I agree to read and abide by the drug screening procedures explained in these materials or by any member of the Veterans Court team.

I understand that if my urine drug screen indicates a positive result for any illegal or non-prescribed drug or alcohol, based on any testing method approved by the Court, at any time while in the program, I will receive a sanction. I understand that the Court will not conduct any evidentiary hearing to allow me to contest such a result and that I will not be allowed to submit any separate results from any other laboratory or testing process. I understand that I will be given the opportunity to request a confirmatory test at my own expense; however I also understand that should *such testing confirm the positive result my sanction will be increased.*

I understand that if I test positive on any alcohol and/or drug test, and the result is obtained while I am present at any court or treatment facility, then I will not be allowed to operate a motor vehicle. I will immediately surrender my automobile keys to staff and call someone for a ride home.

I understand that if I miss, or arrive more than 30 minutes late for, any scheduled drug screen, the test will be presumed to be positive. I understand that any sample which does not contain a sufficient volume of liquid for testing, or which is dilute (that is, which contains a concentration of creatinine less than 20 mg/dl), will be deemed inadequate for testing, and the test will be presumed to be positive. I further understand that, for any such presumed positive test, I will receive a sanction which may include incarceration or termination from the program.

_____ _____

Participant's Signature Date

_____

Print name

SUPERIOR COURT OF COBB COUNTY
VETERANS ACCOUNTABILITY AND TREATMENT COURT

CONSENT FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

I, _____, hereby consent to communication, within or outside my presence, regarding my medical, psychological, or substance abuse history among any of the following individuals: the Veterans Court judge, any Veterans Administration, Veterans Justice Outreach, or Department of Defense employee whose participation in the administration of this program is deemed necessary by the Veterans Court judge, any physician, psychiatrist, or psychologist designated by the Veterans Court or its treatment providers, any prosecutor designated by the District Attorney, any attorney designated by me or by the Cobb County Circuit Defender's Office, any member of the Veterans Court team, and any evaluator or counselor designated by the Veterans Court treatment providers. I understand and agree that the purpose and need for this disclosure is to assist the Court in evaluating and determining my eligibility to participate in Veterans Court as well as my prognosis, compliance and progress in accordance with Veterans Court criteria. I hereby agree to hold such individuals harmless and relieve and release such individuals from any and all liability regarding any such communication.

This consent extends only to that communication which is necessary for and pertinent to hearings and/or reports concerning my specific Veterans Court case. Recipients of this information may not re-disclose it except in connection with my Veterans Court treatment and then only with my written consent, except as permitted by federal law and rules, including but not limited to bona fide medical emergencies, valid court orders, and when there is a suspicion of a danger to others (including suspicion of child abuse or neglect).

Any information obtained through this release is for the exclusive use of the individuals described above. All documents generated by this release shall be kept separate and apart from court file.

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 Veterans Accountability and Treatment Court Program, and/or a formal discontinuation of court proceedings regarding my case.

_____ _____

Participant's Signature Date

_____

Print name

SUPERIOR COURT OF COBB COUNTY
ACCOUNTABILITY COURTS

Fraternization and Harassment Policy for Accountability Courts

The following rules apply to participants in any of the Cobb County Accountability Court programs - that means anyone who is part of Drug Treatment Court, Mental Health Court, Veterans Accountability and Treatment Court, DUI Court or Family Dependency Court.

These rules also apply when you have contact with any member of court staff, which includes:

- Drug lab employees;
- Clerks, secretaries, and support staff who work in the courthouse;
- Security employees such as anyone working at security checkpoints or information desks;
- Sheriff's Office deputies;
- Anyone else who you come in contact with at court or treatment because that person is doing his or her job.

Fraternization

1) You cannot have sex (or any type of sexual contact) with any participant or staff member under any circumstances. You also cannot send sexual messages by phone, internet, social media, or otherwise.

2) You cannot exchange, show, or share any sexually explicit pictures with any other participant or with any staff member.

3) You cannot have a romantic relationship with any participant or staff member. That includes any contact that you hope will lead to a romantic or "dating" relationship. This includes physical contact as well as any communication by phone, internet, social media, or otherwise.

4) You cannot have a romantic or sexual relationship with anyone who has been convicted of a felony crime. The law calls this avoiding "persons and places of disreputable or harmful character." You also cannot live with someone like that, even as roommates. If you plan to date, hang out, or live with someone else, you need to find out ahead of time whether that person is a convicted felon.

5) Friendships (relationships that are not romantic or sexual) may help you in your recovery. But it is also easy to get into trouble if you spend time with the wrong people. So, you cannot spend time with other participants (outside of treatment or court) unless you have told your case manager about it as soon as possible.

6) You can only do the things below if you have gotten permission (before you do it) from the Judge or your case manager:

- Work for the same employer with another participant, even if you're not being paid;
- Give rides to another participant;
- Give or loan each other money or things;
- Perform services for one another that you would normally expect to have to pay for (cutting hair, fixing cars, moving furniture, etc)

7) You cannot sign another participant's attendance sheets for support group meetings or any other documents for the program (such as community service work, etc.)

8) If you are in any relationship that seems to be harmful to your recovery, then you may have to end that relationship to be successful in this program. If treatment believes that a person in your life is hurting your recovery, your counselor will discuss that with you. They may also ask the Judge to tell you whether you can keep having contact with that person.

Harassment

Harassment of any participant or staff member is not allowed. The word "harassment" means any offensive words (spoken or written) or any physical contact that has to do with another person's:

- Race
- Skin color
- Sex (which includes pregnancy, sexual orientation and gender identity)
- Religion
- National origin
- Citizenship
- Age
- Disability

Words that are harassing could be:

- Spoken out loud;
- Written on paper or in an email, text message, or social media post;
- Gestures and body movements that send a message about one of the things listed above;
- Some other form of communication.

The word "harassment" also includes sexual harassment. "Sexual harassment" means speaking or using your body movements in a way that is sexual or romantic, when you know (or should know) that the other person is not seeking sex or romance from you.

With other participants and staff members, you cannot:

- Ask for sex or dates;
- Make sexual or romantic remarks, comments or gestures;
- Show sexually suggestive pictures or videos;
- Touch anyone in a way that they find offensive;
- Talk about sexual or romantic topics in a way another person finds offensive.

By signing below, you agree that if you violate any of the rules listed in this document, you may be sanctioned by the judge of your program. The judge will decide on your sanction based on your individual situation, and your sanction could be community service work, jail, any other sanction the judge decides is appropriate, up to and including termination from the program.

_____ _____

Participant Name Print name

_____

Date

SUPERIOR COURT OF COBB COUNTY
VETERANS ACCOUNTABILITY AND TREATMENT COURT

DISCHARGE POLICY

I understand that, once I have been accepted into this program, I will remain a participant in this program and be subject to all rules and requirements until I am discharged by the entry of a written order of the Veterans Court judge, my completion of certain phase requirements or participation in exit interviews or graduation ceremonies notwithstanding. I understand that a discharge order will only be entered in the event of: 1) successful completion and graduation from the program, 2) termination from the program by order of the Court, or 3) withdrawal by permission of the Veterans Court judge. I understand that I will not at any time have the option to unilaterally withdraw from the program, even if I am facing a sanction.

I further understand that my graduation from this program will be contingent upon the results of a final urine drug screen which will be administered on the day of my scheduled graduation. I understand that a positive result on this test may lead to a sanction, including termination, or to my return to active treatment.

_____ _____

Participant's Signature Date

_____

Print name

Department of Veterans Affairs

REQUEST FOR AND CONSENT TO RELEASE OF MEDICAL RECORDS PROTECTED BY 38 U.S.C. 7332

PAPERWORK REDUCTION ACT INFORMATION: Public reporting burden for this collection of information is estimated to average 2 minutes per response, including the time for reviewing instruction, 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 aspect of this collection of information, including suggestions for reducing the burden to VA Clearance Officer (723), 810 Vermont Avenue NW, Washington DC 20420, and to the Office of Information and Regulatory Affairs, Paperwork Reduction Project (2900-0260), Office of Management and Budget, Washington DC 20503. DO NOT send applications to this address.

☐ 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. and will authorize release of information you specify. Your disclosure of the information requested on this form is voluntary. However, if the information is not furnished, Department of Veterans Affairs will be unable to comply with the request.

ENTER BELOW THE PATIENT'S NAME AND SOCIAL SECURITY NUMBER IF THE PATIENT DATA CARD IMPRINT IS NOT USED.

TO: **Department of Veterans Affairs**
Atlanta VA Health Care System
Attn: Medical Records Department
1670 Clairmont Road
Decatur, GA 30033

PATIENT NAME (Last, First, Middle Initial)
X

SOCIAL SECURITY NUMBER
X

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED.
Cobb County Veterans Treatment Court: County Court and Administration Staff, Private Attorney, Public Defender, Community Supervision Officers and Staff, Family Members, Jail Staff, Vet Center and Staff, Community/Private Medical, Mental Health and Substance Use Treatment Programs.

VETERAN'S REQUEST: I request and authorize Department of Veterans Affairs to release the information specified below to the organization, or individual named on this request. I understand that the information to be released included information regarding the following condition(s):

☒ DRUG ABUSE ☒ ALCOHOLISM OR ALCOHOL ABUSE ☐ TESTING FOR OR INFECTION WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV) ☐ SICKLE CELL ANEMIA

INFORMATION REQUESTED: (Check applicable box(es) and state the extent or nature of the information to be disclosed, giving the dates or approximate dates covered by each)

☒ Copy of Hospital Summary ☒ Copy of Outpatient Treatment Note(s) ☒ Other

TX Summary: Initial Assessment, Diagnoses, Medications, Treatment Plans, UA Results, Psychotherapy Progress Notes, Psychological Testing Results, Family Therapy Notes, Discharge Summaries, and Test Results (COVID 19, TB and RPR). Reporting of progress during treatment (medical, mental health and substance use treatment).

Purpose(s) or need for which the information is to be used:

☒ Assist client in meeting legal requirements ☒ Coordination of Care ☒ Transfer Tx to another agency ☒ Assist with housing ☒ Other: Medical, Mental Health and Substance Use Treatment Psychotherapy and Progress Notes from providers outside of the VA.

AUTHORIZATION: I provide consent to participate in tele-health services and to have my personal health information released via tele-health access with Veterans Treatment Court. I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time except to the extent that action has already been taken to comply with it. Redisclosure of my medical records by those receiving the above authorized information may not be accomplished without my further written consent. Without my express revocation, the consent will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on : or (3) under the following condition(s):

Date: X	**Signature of Patient or Person Authorized to Sign for Patient** X

FOR VA USE ONLY

IMPRINT Patient Data Card (Name, Address, Social Security Number)	Type and Extent of Material Released	
	Date Released	Released By:

VA FORM **10-5345 (R) (663 Automated)**

Department of Veterans Affairs

INSTRUCTIONS FOR COMPLETING ENROLLMENT APPLICATION FOR HEALTH BENEFITS

Please Read Before You Start . . . What is VA Form 10-10EZ used for?

For Veterans to apply for enrollment in the VA health care system. The information provided on this form will be used by VA to determine your eligibility for medical benefits and on average will take 30 minutes to complete. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

Where can I get help filling out the form and if I have questions?

You may use ANY of the following to request assistance:

- Ask VA to help you fill out the form by calling us at 1-877-222-VETS (8387).
- Access VA's website at http://www.va.gov and select "Contact the VA."
- Contact the Enrollment Coordinator at your local VA health care facility.
- Contact a National or State Veterans Service Organization.

Definitions of terms used on this form:

SERVICE-CONNECTED (SC): A VA determination that an illness or injury was incurred or aggravated in the line of duty, in the active military, naval or air service.

COMPENSABLE: A VA determination that a service-connected disability is severe enough to warrant monetary compensation.

NONCOMPENSABLE: A VA determination that a service-connected disability is not severe enough to warrant monetary compensation.

NONSERVICE-CONNECTED (NSC): A Veteran who does not have a VA determined service-related condition.

Getting Started: **ALL VETERANS MUST COMPLETE SECTIONS I - III.**

Directions for Sections I - III:

Section I - General Information: Answer all questions.

Section II - Military Service Information: If you are not currently receiving benefits from VA, you may attach a copy of your discharge or separation papers from the military (such as DD-214 or, for WWII Veterans, a "WD" Form), with your signed application to expedite processing of your application. If you are currently receiving benefits from VA, we will cross-reference your information with VA data.

Section III - Insurance Information: Include information for all health insurance companies that cover you, this includes coverage provided through a spouse or significant other. Bring your insurance cards, Medicare and/or Medicaid card with you to each health care appointment.

Directions for Sections IV-VI:

Financial Disclosure: ONLY NSC AND 0% NONCOMPENSABLE SC VETERANS MUST COMPLETE THIS SECTION TO DETERMINE ELIGIBILITY FOR VA HEALTH CARE ENROLLMENT AND/OR CARE OR SERVICES.

Financial Disclosure Requirements Do Not Apply To:

- a former Prisoner of War; or
- those in receipt of a Purple Heart; or
- a recently discharged Combat Veteran; or
- those discharged for a disability incurred or aggravated in the line of duty; or
- those receiving VA SC disability compensation; or
- those receiving VA pension; or
- those in receipt of Medicaid benefits; or
- those who served in Vietnam between January 9, 1962 and May 7, 1975; or
- those who served in SW Asia during the Gulf War between August 2, 1990 and November 11, 1998; or
- those who served at least 30 days at Camp Lejeune between August 1, 1953 and December 31, 1987.

You are not required to disclose your financial information; however, VA is not currently enrolling new applicants who decline to provide their financial information unless they have other qualifying eligibility factors. If a financial assessment is not used to determine your priority for enrollment you may choose not to disclose your information. However, if a financial assessment is used to determine your eligibility for cost-free medication, travel assistance or waiver of the travel deductible, and you do not disclose your financial information, you will not be eligible for these benefits.

Section IV - Dependent Information: Include the following:

- Your spouse even if you did not live together, as long as you contributed support last calendar year.
- Your biological children, adopted children, and stepchildren who are unmarried and under the age of 18, or at least 18 but under 23 and attending high school, college or vocational school (full or part-time), or became permanently unable to support themselves before age 18.
- Child support contributions. Contributions can include tuition or clothing payments or payments of medical bills.

Continued ...

Section V - Employment Information:

- Veterans Employment Status
- Date of Retirement
- Company Name
- Company Address
- Company Phone Number

Section VI - Previous Calendar Year Gross Annual Income of Veteran, Spouse and Dependent Children

Report:

- Gross annual income from employment, except for income from your farm, ranch, property or business. Include your wages, bonuses, tips, severance pay and other accrued benefits and your child's income information if it could have been used to pay your household expenses.
- Net income from your farm, ranch, property, or business.
- Other income amounts, including retirement and pension income, Social Security Retirement and Social Security Disability income, compensation benefits such as VA disability, unemployment, Workers and black lung, cash gifts, interest and dividends, including tax exempt earnings and distributions from Individual Retirement Accounts (IRAs) or annuities.

Do Not Report:

Donations from public or private relief, welfare or charitable organizations; Supplemental Security Income (SSI) and need-based payments from a government agency; profit from the occasional sale of property; income tax refunds, reinvested interest on Individual Retirement Accounts (IRAs); scholarships and grants for school attendance; disaster relief payments; reimbursement for casualty loss; loans; Radiation Compensation Exposure Act payments; Agent Orange settlement payments; Alaska Native Claims Settlement Acts Income, payments to foster parent; amounts in joint accounts in banks and similar institutions acquired by reason of death of the other joint owner; Japanese ancestry restitution under Public Law 100-383; cash surrender value of life insurance; lump-sum proceeds of life insurance policy on a Veteran; and payments received under the Medicare transitional assistance program.

Section VII - Previous Calendar Year Deductible Expenses

Report non-reimbursed medical expenses paid by you or your spouse. Include expenses for medical and dental care, drugs, eyeglasses, Medicare, medical insurance premiums and other health care expenses paid by you for dependents and persons for whom you have a legal or moral obligation to support. Do not list expenses if you expect to receive reimbursement from insurance or other sources. Report last illness and burial expenses, e.g., prepaid burial, paid by the Veteran for spouse or dependent(s).

Section VIII - Consent to Copays and to Receive Communications

By submitting this application, you are agreeing to pay the applicable VA copayments for care or services (including urgent care) as required by law. You also agree to receive communications from VA to your supplied email, home phone number, or mobile number. However, providing your email, home phone number, or mobile number is voluntary.

Submitting Your Application

1. You or an individual to whom you have delegated your Power of Attorney must sign and date the form. If you sign with an "X", 2 people you know must witness you as you sign. They must sign the form and print their names. If the form is not signed and dated appropriately, VA will return it for you to complete.
2. Attach any continuation sheets, a copy of supporting materials and your Power of Attorney documents to your application.

Where do I send my application?

Mail the original application and supporting materials to the Health Eligibility Center, 2957 Clairmont Road, Suite 200, Atlanta, GA 30329.

PAPERWORK REDUCTION ACT AND PRIVACY 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 Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 30 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

Privacy Act Information: VA is asking you to provide the information on this form under 38 U.S.C. Sections 1705,1710, 1712, and 1722 in order for VA to determine your eligibility for medical benefits. Information you supply may be verified from initial submission forward through a computer-matching program. 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 systems of records notices and in accordance with the VHA Notice of Privacy Practices. Providing the requested information is voluntary, but if any or all of the requested information is not provided, it may delay or result in denial of your request for health care benefits. Failure to furnish the information will not have any effect on any other benefits to which you may be entitled. If you provide VA your Social Security Number, VA will use it to administer your VA benefits. VA may also use this information to identify Veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

OMB Control No. 2900-0091
Estimated Burden Avg. 30 min.
Expiration Date 12/31/2020

Department of Veterans Affairs — APPLICATION FOR HEALTH BENEFITS

SECTION I - GENERAL INFORMATION

Federal law provides criminal penalties, including a fine and/or imprisonment for up to 5 years, for concealing a material fact or making a materially false statement. (See 18 U.S.C. 1001)

1A. VETERAN'S NAME *(Last, First, Middle Name)*	1B. PREFERRED NAME	2. MOTHER'S MAIDEN NAME

3A. BIRTH SEX	3B. SELF-IDENTIFIED GENDER IDENTITY	4. ARE YOU SPANISH, HISPANIC, OR LATINO?	5. WHAT IS YOUR RACE? *(You may check more than one. Information is required for statistical purposes only.)*	6. SOCIAL SECURITY NO.
☐ MALE ☐ FEMALE	☐ MALE ☐ FEMALE	☐ YES ☐ NO	☐ ASIAN ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ BLACK OR AFRICAN AMERICAN ☐ WHITE ☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER	

7. VA CLAIM NUMBER	8A. DATE OF BIRTH *(mm/dd/yyyy)*	8B. PLACE OF BIRTH *(City and State)*	9. RELIGION

10A. PERMANENT ADDRESS *(Street)*	10B. CITY	10C. STATE	10D. ZIP CODE	10E. COUNTY

10F. HOME TELEPHONE NO. *(optional)* *(Include Area Code)*	10G. MOBILE TELEPHONE NO. *(optional)* *(Include Area Code)*	10H. E-MAIL ADDRESS *(optional)*

11A. RESIDENTIAL ADDRESS *(Street)*	11B. CITY	11C. STATE	11D. ZIP CODE	11E. COUNTY

12. TYPE OF BENEFIT(S) APPLYING FOR *(You may check more than one)*	13. CURRENT MARTIAL STATUS
☐ ENROLLMENT/HEALTH SERVICES ☐ DENTAL	☐ MARRIED ☐ NEVER MARRIED ☐ SEPARATED ☐ WIDOWED ☐ DIVORCED

14A. NEXT OF KIN NAME	14B. NEXT OF KIN ADDRESS	14C. NEXT OF KIN RELATIONSHIP

14D. NEXT OF KIN TELEPHONE NO. *(Include Area Code)*	14E. NEXT OF KIN WORK TELEPHONE NO. *(Include Area Code)*	15. DESIGNEE - INDIVIDUAL TO RECEIVE POSSESSION OF YOUR PERSONAL PROPERTY LEFT ON PREMISES UNDER VA CONTROL AFTER YOUR DEPARTURE OR AT THE TIME OF DEATH *(Note: This does not constitute a will or transfer of title)*

16. I AM ENROLLING TO OBTAIN MINIMUM ESSENTIAL COVERAGE UNDER THE AFFORDABLE CARE ACT	17. WHICH VA MEDICAL CENTER OR OUTPATIENT CLINIC DO YOU PREFER? *(for listing of facilities visit www.va.gov/directory)*	18. WOULD YOU LIKE FOR VA TO CONTACT YOU TO SCHEDULE YOUR FIRST APPOINTMENT?
☐ YES ☐ NO		☐ YES ☐ NO

SECTION II - MILITARY SERVICE INFORMATION

1A. LAST BRANCH OF SERVICE	1B. LAST ENTRY DATE	1C. FUTURE DISCHARGE DATE	1D. LAST DISCHARGE DATE

1E. DISCHARGE TYPE	1F. MILITARY SERVICE NUMBER

2. MILITARY HISTORY *(Check yes or no)*	YES	NO		YES	NO
A. ARE YOU A PURPLE HEART AWARD RECIPIENT?	☐	☐	G. DO YOU HAVE A VA SERVICE-CONNECTED RATING?	☐	☐
B. ARE YOU A FORMER PRISONER OF WAR?	☐	☐	IF "YES", WHAT IS YOUR RATED PERCENTAGE _____ %		
C. DID YOU SERVE IN A COMBAT THEATER OF OPERATIONS AFTER 11/11/1998?	☐	☐	H. DID YOU SERVE IN VIETNAM BETWEEN JANUARY 9, 1962 AND MAY 7, 1975?	☐	☐
D. WERE YOU DISCHARGED OR RETIRED FROM MILITARY FOR A DISABILITY INCURRED IN THE LINE OF DUTY?	☐	☐	I. WERE YOU EXPOSED TO RADIATION WHILE IN THE MILITARY?	☐	☐
E. ARE YOU RECEIVING DISABILITY RETIREMENT PAY INSTEAD OF VA COMPENSATION?	☐	☐	J. DID YOU RECEIVE NOSE AND THROAT RADIUM TREATMENTS WHILE IN THE MILITARY?	☐	☐
F. DID YOU SERVE IN SW ASIA DURING THE GULF WAR BETWEEN AUGUST 2, 1990 AND NOVEMBER 11, 1998?	☐	☐	K. DID YOU SERVE ON ACTIVE DUTY AT LEAST 30 DAYS AT CAMP LEJEUNE FROM AUGUST 1, 1953 THROUGH DECEMBER 31, 1987?	☐	☐

APPLICATION FOR HEALTH BENEFITS *Continued*	VETERAN'S NAME *(Last, First, Middle)*	SOCIAL SECURITY NUMBER

SECTION III - INSURANCE INFORMATION *(Use a separate sheet for additional information)*

1. ENTER YOUR HEALTH INSURANCE COMPANY NAME, ADDRESS AND TELEPHONE NUMBER *(include coverage through spouse or other person)*

2. NAME OF POLICY HOLDER	3. POLICY NUMBER	4. GROUP CODE	5. ARE YOU ELIGIBLE FOR MEDICAID? ☐ YES ☐ NO	6A. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART A? ☐ YES ☐ NO 6B. EFFECTIVE DATE *(mm/dd/yyyy)*

SECTION IV - DEPENDENT INFORMATION *(Use a separate sheet for additional dependents)*

1. SPOUSE'S NAME *(Last, First, Middle Name)*		2. CHILD'S NAME *(Last, First, Middle Name)*	
1A. SPOUSE'S SOCIAL SECURITY NUMBER		2A. CHILD'S DATE OF BIRTH *(mm/dd/yyyy)*	2B. CHILD'S SOCIAL SECURITY NO.
1B. SPOUSE'S DATE OF BIRTH *(mm/dd/yyyy)*	1C. SPOUSE SELF-IDENTIFIED GENDER IDENTITY ☐ MALE ☐ FEMALE	2C. DATE CHILD BECAME YOUR DEPENDENT *(mm/dd/yyyy)*	
1D. DATE OF MARRIAGE *(mm/dd/yyyy)*		2D. CHILD'S RELATIONSHIP TO YOU *(Check one)* ☐ SON ☐ DAUGHTER ☐ STEPSON ☐ STEPDAUGHTER	
1E. SPOUSE'S ADDRESS AND TELEPHONE NUMBER *(Street, City, State, ZIP if different from Veteran's)*		2E. WAS CHILD PERMANENTLY AND TOTALLY DISABLED BEFORE THE AGE OF 18? ☐ YES ☐ NO 2F. IF CHILD IS BETWEEN 18 AND 23 YEARS OF AGE, DID CHILD ATTEND SCHOOL LAST CALENDAR YEAR? ☐ YES ☐ NO	
1F. IF YOUR SPOUSE OR DEPENDENT CHILD DID NOT LIVE WITH YOU LAST YEAR, DID YOU PROVIDE SUPPORT? ☐ YES ☐ NO		2G. EXPENSES PAID BY YOUR DEPENDENT CHILD FOR COLLEGE, VOCATIONAL REHABILITATION OR TRAINING *(e.g., tuition, books, materials)*	

SECTION V - EMPLOYMENT INFORMATION

1A. VETERAN'S EMPLOYMENT STATUS *(Check one)*. ☐ FULL TIME ☐ PART TIME ☐ NOT EMPLOYED ☐ RETIRED	1B. DATE OF RETIREMENT	
1C. COMPANY NAME. *(Complete if employed or retired)*	1D. COMPANY ADDRESS *(Complete if employed or retired - Street, City, State, ZIP)*	1E. COMPANY PHONE NUMBER *(Complete if employed or retired) (Include area code)*

SECTION VI - PREVIOUS CALENDAR YEAR GROSS ANNUAL INCOME OF VETERAN, SPOUSE AND DEPENDENT CHILDREN *(Use a separate sheet for additional dependents)*

	VETERAN	SPOUSE	CHILD 1
1. GROSS ANNUAL INCOME FROM EMPLOYMENT *(wages, bonuses, tips, etc.)* EXCLUDING INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS	$	$	$
2. NET INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS	$	$	$
3. LIST OTHER INCOME AMOUNTS *(e.g., Social Security, compensation, pension interest, dividends)* EXCLUDING WELFARE.	$	$	$

SECTION VII - PREVIOUS CALENDAR YEAR DEDUCTIBLE EXPENSES

1. TOTAL NON-REIMBURSED MEDICAL EXPENSES PAID BY YOU OR YOUR SPOUSE *(e.g., payments for doctors, dentists, medications, Medicare, health insurance, hospital and nursing home) VA will calculate a deductible and the net medical expenses you may claim.*	$
2. AMOUNT YOU PAID LAST CALENDAR YEAR FOR FUNERAL AND BURIAL EXPENSES (INCLUDING PREPAID BURIAL EXPENSES) FOR YOUR DECEASED SPOUSE OR DEPENDENT CHILD *(Also enter spouse or child's information in Section VI.)*	$
3. AMOUNT YOU PAID LAST CALENDAR YEAR FOR YOUR COLLEGE OR VOCATIONAL EDUCATIONAL EXPENSES *(e.g., tuition, books, fees, materials) DO NOT LIST YOUR DEPENDENTS' EDUCATIONAL EXPENSES.*	$

APPLICATION FOR HEALTH BENEFITS *Continued*	VETERAN'S NAME *(Last, First, Middle)*	SOCIAL SECURITY NUMBER

SECTION VIII - CONSENT TO COPAYS AND TO RECEIVE COMMUNICATIONS

By submitting this application, you are agreeing to pay the applicable VA copayments for care or services (including urgent care) as required by law. You also agree to receive communications from VA to your supplied email, home phone number, or mobile number. However, providing your email, home phone number, or mobile number is voluntary.

ASSIGNMENT OF BENEFITS

I understand that pursuant to 38 U.S.C. Section 1729 and 42 U.S.C. 2651, the Department of Veterans Affairs (VA) is authorized to recover or collect from my health plan (HP) or any other legally responsible third party for the reasonable charges of nonservice-connected VA medical care or services furnished or provided to me. I hereby authorize payment directly to VA from any HP under which I am covered (including coverage provided under my spouse's HP) that is responsible for payment of the charges for my medical care, including benefits otherwise payable to me or my spouse. Furthermore, I hereby assign to the VA any claim I may have against any person or entity who is or may be legally responsible for the payment of the cost of medical services provided to me by the VA. I understand that this assignment shall not limit or prejudice my right to recover for my own benefit any amount in excess of the cost of medical services provided to me by the VA or any other amount to which I may be entitled. I hereby appoint the Attorney General of the United States and the Secretary of Veterans' Affairs and their designees as my Attorneys-in-fact to take all necessary and appropriate actions in order to recover and receive all or part of the amount herein assigned. I hereby authorize the VA to disclose, to my attorney and to any third party or administrative agency who may be responsible for payment of the cost of medical services provided to me, information from my medical records as necessary to verify my claim. Further, I hereby authorize any such third party or administrative agency to disclose to the VA any information regarding my claim.

ALL APPLICANTS MUST SIGN AND DATE THIS FORM. REFER TO INSTRUCTIONS WHICH DEFINE WHO CAN SIGN ON BEHALF OF THE VETERAN.

SIGNATURE OF APPLICANT
(Sign in ink)

DATE

INSTRUCTION AND INFORMATION SHEET FOR SF 180, REQUEST PERTAINING TO MILITARY RECORDS

1. General Information. The Standard Form 180, Request Pertaining to Military Records (SF180) is used to request information from military records. Certain identifying information is necessary to determine the location of an individual's record of military service. Please try to answer each item on the SF 180. If you do not have and cannot obtain the information for an item, show "NA," meaning the information is "not available". Include as much of the requested information as you can. Incomplete information may delay response time. To determine where to mail this request see Page 2 of the SF180 for record locations and facility addresses.

Online requests may be submitted to the National Personnel Records Center (NPRC) by a veteran or deceased veteran's next-of-kin using eVetRecs at http://www.archives.gov/veterans/military-service-records/ .

2. Personnel Records/Military Human Resource Records/Official Military Personnel File (OMPF) and Medical Records/Service Treatment Records (STR). Personnel records of military members who were discharged, retired, or died in service **LESS THAN 62 YEARS AGO** and medical records are in the legal custody of the military service department and are administered in accordance with rules issued by the Department of Defense and the Department of Homeland Security (DHS, Coast Guard). STRs of persons on active duty are generally kept at the local servicing clinic. After the last day of active duty, STRs should be requested from the appropriate address on page 2 of the SF 180. (See item 3, Archival Records, if the military member was discharged, retired or died in service more than 62 years ago.)

a. Release of information: Release of information is subject to restrictions imposed by the military services consistent with Department of Defense regulations, the provisions of the Freedom of Information Act (FOIA) and the Privacy Act of 1974. The service member (either past or present) or the member's legal guardian has access to almost any information contained in that member's own record. The authorization signature of the service member or the member's legal guardian is needed in Section III of the SF180. Others requesting information from military personnel records and/or STRs must have the release authorization in Section III of the SF 180 signed by the member or legal guardian. If the appropriate signature cannot be obtained, only limited types of information can be provided. If the former member is deceased, the surviving next-of-kin may, under certain circumstances, be entitled to greater access to a deceased veteran's records than a member of the general public. The next-of-kin may be any of the following: unremarried surviving spouse, father, mother, son, daughter, sister, or brother. Requesters **MUST provide proof of death, such as a copy of a death certificate, newspaper article (obituary) or death notice, coroner's report of death, funeral director's signed statement of death, or verdict of coroner's jury.**

b. Fees for records: There is no charge for most services provided to service members or next-of-kin of deceased veterans. A nominal fee is charged for certain types of service. In most instances, service fees cannot be determined in advance. If your request involves a service fee, you will receive an invoice with your records.

3. Archival Records. Personnel records of military members who were discharged, retired, or died in service **62 OR MORE YEARS AGO** have been transferred to the legal custody of NARA and are referred to as "archival records".

a. Release of Information: Archival records are open to the public. The Privacy Act of 1974 does not apply to archival records, therefore, written authorization from the veteran or next-of-kin is not required. In order to protect the privacy of the veteran, his/her family, and third parties named in the records, the personal privacy exemption of the Freedom of Information Act (5 U.S.C. 552 (b) (6)) may still apply and may preclude the release of some information.

b. Fees for Archival Records: Access to archival records are granted by offering copies of the records for a fee (44 U.S.C. 2116 (c)). If a fee applies to the photocopies of documents in the requested record, you will receive an invoice. Photocopies will be sent after payment is made. For more information see http://www.archives.gov/st-louis/archival-programs/military-personnel-archival/ompf-archival-requests.html.

4. Where reply may be sent. The reply may be sent to the service member or any other address designated by the service member or other authorized requester. If the designated address is NOT registered to the addressee by the U.S. Postal Service (USPS), provide BOTH the addressee's name AND "in care of" (c/o) the name of the person to whom the address is registered on the NAME line in Section III, item 3, on page 1 of the SF 180. The COMPLETE address must be provided, INCLUDING any apartment/suite/unit/lot/space/etc. number.

5. Definitions and abbreviations. DISCHARGED -- the individual has no current military status; SERVICE TREATMENT RECORD (STR) -- The chronology of medical, mental health, and dental care received by service members during the course of their military career (does not include records of treatment while hospitalized); TDRL – Temporary Disability Retired List.

6. Service completed before World War I. National Archives Trust Fund (NATF) forms must be used to request these records. Obtain the forms by e-mail from *inquire@nara.gov* or write to the Code 6 address on page 2 of the SF 180.

PRIVACY ACT OF 1974 COMPLIANCE INFORMATION

The following information is provided in accordance with 5 U.S.C. 552a(e)(3) and applies to this form. Authority for collection of the information is 44 U.S.C. 2907, 3101, and 3103, and Public Law 104-134 (April 26, 1996), as amended in title 31, section 7701. Disclosure of the information is voluntary. If the requested information is not provided, it may delay servicing your inquiry because the facility servicing the service member's record may not have all of the information needed to locate it. The purpose of the information on this form is to assist the facility servicing the records (see the address list) in locating the correct military service record(s) or information to answer your inquiry. This form is then retained as a record of disclosure. The form may also be disclosed to Department of Defense components, the Department of Veterans Affairs, the Department of Homeland Security (DHS, U.S. Coast Guard), or the National Archives and Records Administration when the original custodian of the military health and personnel records transfers all or part of those records to that agency. If the service member was a member of the National Guard, the form may also be disclosed to the Adjutant General of the appropriate state, District of Columbia, or Puerto Rico, where he or she served.

PAPERWORK REDUCTION ACT PUBLIC BURDEN STATEMENT

Public burden reporting for this collection of information is estimated to be five minutes per request, including time for reviewing instructions and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of the collection of information, including suggestions for reducing this burden, to National Archives and Records Administration (ISSD), 8601 Adelphi Road, College Park, MD 20740-6001. *DO NOT SEND COMPLETED FORMS TO THIS ADDRESS.* SEND COMPLETED FORMS TO THE APPROPRIATE ADDRESS LISTED ON PAGE 2 OF THE SF 180.

Standard Form 180 (Rev. 11/2015) (Page 1)
Prescribed by NARA (36 CFR 1233.18 (d))
Authorized for local reproduction
Previous edition unusable
OMB No. 3095-0029 Expires 04/30/2021

REQUEST PERTAINING TO MILITARY RECORDS

Requests from veterans or deceased veteran's next-of-kin may be submitted online by using eVetRecs at http://www.archives.gov/veterans/military-service-records/
To ensure the best possible service, please thoroughly review the accompanying instructions before filling out this form. PLEASE PRINT LEGIBLY OR TYPE BELOW.

SECTION I - INFORMATION NEEDED TO LOCATE RECORDS *(Furnish as much information as possible.)*

1. NAME USED DURING SERVICE (last, first, full middle)	2. SOCIAL SECURITY #	3. DATE OF BIRTH	4. PLACE OF BIRTH

5. SERVICE, PAST AND PRESENT *(For an effective records search, it is important that ALL service be shown below.)*

	BRANCH OF SERVICE	DATE ENTERED	DATE RELEASED	OFFICER	ENLISTED	SERVICE NUMBER (If unknown, write "unknown")
a. ACTIVE				☐	☐	
b. RESERVE				☐	☐	
c. STATE NATIONAL GUARD				☐	☐	

6. IS THIS PERSON DECEASED? ☐ NO ☐ YES - *MUST provide Date of Death if veteran is deceased:* _____

7. DID THIS PERSON RETIRE FROM MILITARY SERVICE? ☐ NO ☐ YES

SECTION II - INFORMATION AND/OR DOCUMENTS REQUESTED

1. CHECK THE ITEM(S) YOU ARE REQUESTING:

☐ **DD Form 214 or equivalent.** Year(s) in which form(s) issued to veteran: _____
This form contains information normally needed to verify military service. A copy may be sent to the veteran, the deceased veteran's next-of-kin, or other persons or organizations, if authorized in Section III, below. **An UNDELETED DD214 is ordinarily required to determine eligibility for benefits.** If you request a DELETED copy, the following items will be blacked out: authority for separation, reason for separation, reenlistment eligibility code, separation (SPD/SPN) code, and, for separations after June 30, 1979, character of separation and dates of time lost.
An UNDELETED copy will be sent UNLESS YOU SPECIFY A DELETED COPY by checking this box: ☐ I want a **DELETED** copy.

☐ **Medical Records** Includes Service Treatment Records, Health (outpatient) and Dental Records. ***IF HOSPITALIZED (inpatient) the FACILITY NAME and DATE (month and year) for EACH admission MUST be provided:*** _____

☐ **Other (Specify):** _____

2. PURPOSE: (Providing information about the purpose of the request is **strictly voluntary**; however, it may help to provide the best possible response and may result in a faster reply. Information provided will in no way be used to make a decision to deny the request.)

☐ Benefits (explain) ☐ Employment ☐ VA Loan Programs ☐ Medical ☐ Genealogy ☐ Correction ☐ Personal ☐ Other (explain)

Explain here: _____

SECTION III - RETURN ADDRESS AND SIGNATURE

1. REQUESTER NAME: _____

2. ☐ I am the MILITARY SERVICE MEMBER OR VETERAN identified in Section I, above.

☐ I am the DECEASED VETERAN'S NEXT-OF-KIN *(MUST submit Proof of Death. See item 2a on instruction sheet.)*

(Relationship to deceased veteran)

☐ I am the VETERAN'S LEGAL GUARDIAN *(MUST submit copy of Court Appointment)* or AUTHORIZED REPRESENTATIVE *(MUST submit copy of Authorization Letter or Power of Attorney)*

☐ OTHER

(Specify type of Other)

3. SEND INFORMATION/DOCUMENTS TO:
(Please print or type. See item 4 on accompanying instructions.)

Name

Street Apt.

City State Zip Code

* This form is available at *http://www.archives.gov/veterans/military-service-records/standard-form-180.html* on the National Archives and Records Administration (NARA) web site. *

4. AUTHORIZATION SIGNATURE: I declare (or certify, verify, or state) under penalty of perjury under the laws of the United States of America that the information in this Section III is true and correct and that I authorize the release of the requested information. *(See items 2a or 3a on accompanying instruction sheet. Without the Authorization Signature of the veteran, next-of-kin of deceased veteran, veteran's legal guardian, authorized government agent, or other authorized representative, only limited information can be released unless the request is archival. No signature is required if the request if for archival records.)*

Signature Required - Do not print Date

Daytime phone Fax Number

Email address

The various categories of military service records are described in the chart below. For each category there is a code number which indicates the address at the bottom of the page to which this request should be sent. Please refer to the Instruction and Information Sheet accompanying this form as needed.

BRANCH	CURRENT STATUS OF SERVICE MEMBER	Personnel Record	Medical or Service Treatment Record
AIR FORCE	Discharged, deceased, or retired before 5/1/1994	14	14
	Discharged, deceased, or retired 5/1/1994 – 9/30/2004	14	11
	Discharged, deceased, or retired 10/1/2004 – 12/31/2013	1	11
	Discharged, deceased, or retired on or after 1/1/2014	1	13
	Active (including National Guard on active duty in the Air Force), TDRL, or general officers retired with pay	1	
	Reserve, IRR, Retired Reserve in non-pay status, current National Guard officers not on active duty in the Air Force, or National Guard released from active duty in the Air Force	2	
	Current National Guard enlisted not on active duty in the Air Force	2	13
COAST GUARD	Discharge , deceased, or retired before 1/1/1898	6	
	Discharged, deceased, or retired 1/1/1898 – 3/31/1998	14	14
	Discharged, deceased, or retired 4/1/1998 – 9/30/2006	14	11
	Discharged, deceased, or retired 10/1/2006 – 9/30/2013	3	11
	Discharged, deceased, or retired on or after 10/1/2013	3	14
	Active, Reserve, Individual Ready Reserve or TDRL	3	
MARINE CORPS	Discharged, deceased, or retired before 1/1/1895	6	
	Discharged, deceased, or retired 1/1/1905 – 4/30/1994	14	14
	Discharged, deceased, or retired 5/1/1994 – 12/31/1998	14	11
	Discharged, deceased, or retired 1/1/1999 - 12/31/2013	4	11
	Discharged, deceased, or retired on or after 1/1/2014	4	8
	Individual Ready Reserve	5	
	Active, Selected Marine Corps Reserve, TDRL	4	
ARMY	Discharged, deceased, or retired before 11/1/1912 (enlisted) or before 7/1/1917 (officer)	6	
	Discharged, deceased, or retired 11/1/1912 – 10/15/1992 (enlisted) or 7/1/1917 – 10/15/1992 (officer)	14	
	Discharged, deceased, or retired 10/16/1992 – 9/30/2002	14	11
	Discharged, deceased, or retired (including TDRL) 10/1/2002 – 12/31/2013	7	11
	Discharged, deceased, or retired (including TDRL) on or after 1/1/2014	7	9
	Current Soldier (Active, Reserve (including Individual Ready Reserve) or National Guard)	7	
NAVY	Discharged, deceased, or retired before 1/1/1886 (enlisted) or before 1/1/1903 (officer)	6	
	Discharged, deceased, or retired 1/1/1886 – 1/30/1994 (enlisted) or 1/1/1903 – 1/30/1994 (officer)	14	14
	Discharged, deceased, or retired 1/31/1994 – 12/31/1994	14	11
	Discharged, deceased, or retired 1/1/1995 – 12/31/2013	10	11
	Discharged, deceased, or retired on or after 1/1/2014	10	8
	Active, Reserve, or TDRL	10	
PHS	Public Health Service - Commissioned Corps officers only	12	

ADDRESS LIST OF CUSTODIANS and SELF-SERVICE WEBSITES (BY CODE NUMBERS SHOWN ABOVE) – Where to write/send this form

1 Air Force Personnel Center
HQ AFPC/DPSIRP
550 C Street West, Suite 19
Randolph AFB, TX 78150-4721

2 Air Reserve Personnel Center
Records Management Branch (DPTSC)
18420 E. Silver Creek Avenue
Building 390 MS 68
Buckley AFB, CO 80011

3 Commander, Personnel Service Center
(BOPS-C-MR) MS7200
US Coast Guard
2703 Martin Luther King Jr Ave SE
Washington, DC 20593-7200
MR_CustomerService@uscg.mil

4 Headquarters U.S. Marine Corps
Manpower Management Records & Performance
(MMRP-10)
2008 Elliot Road
Quantico, VA 22134-5030

5 Marine Forces Reserve
2000 Opelousas Avenue
New Orleans, LA 70146-5400

6 National Archives & Records Administration
Research Services (RDT1R)
700 Pennsylvania Avenue NW
Washington, DC 20408-0001

7 US Army Human Resources Command's web page:
https://www.hrc.army.mil/TAGD/Accessing%20or%20Requesting%20Your%20Official%20Military%20Personnel%20File%20Documents
or 1-888-ARMYHRC (1-888-276-9472)

8 Navy Medicine Records Activity (NMRA)
BUMED Detachment St. Louis
4300 Goodfellow Boulevard, Building 103
St. Louis, MO 63120

9 AMEDD Record Processing Center
3370 Nacogdoches Road, Suite 116
San Antonio, TX 78217

10 Navy Personnel Command (PERS-313)
5720 Integrity Drive
Millington, TN 38055-3120

11 Department of Veterans Affairs
Records Management Center
ATTN: Release of Information
P.O. Box 5020
St. Louis, MO 63115-5020

12 Division of Commissioned Corps Officer Support
ATTN: Records Officer
1101 Wooton Parkway, Plaza Level, Suite 100
Rockville, MD 20852

13 AF STR Processing Center
ATTN: Release of Information
3370 Nacogdoches Road, Suite 116
San Antonio, TX 78217

14 National Personnel Records Center
(Military Personnel Records)
1 Archives Drive
St. Louis, MO 63138-1002

*e*VetRecs:
https://www.archives.gov/veterans/military-service-records

Highland Rivers Behavioral Health

RELEASE OF INFORMATION

FILL OUT EACH SECTION WHERE INDICATED | **Individual's Name:**

Section A – Authorization: [READ]

By signing this form, I authorize Highland Rivers Behavioral Health, including any affiliated program, to use and disclose my individually-identifiable health information as specified below:

Section B – Authorized Recipients: [FILL-IN]

My information may be disclosed to / from: _____

Address:

Section C: Designation of records to be released [CHECK ALL THAT APPLY]

- ☐ Psychiatric/Psychological Records (evaluation, assessment, treatment, attendance and discharge plan)
- ☐ Substance Use Disorder Treatment Records (assessment, treatment, attendance and discharge plan)
- ☐ Individual Service Recovery Plan
- ☐ Other: [specify]
- ☐ HIV/AIDS
- ☐ Clinic & Doctor Notes
- ☐ Progress Notes
- ☐ Rehabilitation Plan
- ☐ Individual Education Support Plan/Family
- ☐ Group Notes
- ☐ Drug Screens
- ☐ Test/Lab Results
- ☐ Prescribed Medications

Section D: Purpose of Disclosure [MUST CHECK AT LEAST ONE]

- ☐ Continuity of care
- ☐ Coordination of services
- ☐ Adherence to subpoena(s)
- ☐ If information is **not** substance use related and individual declines to state purpose check here.
- ☐ Determination of benefits
- ☐ Determination of eligibility
- ☐ Representation of Individual
- ☐ Compliance with services and treatment plan
- ☐ Compliance with court ordered treatment plan
- ☐ Treatment outcome and effectiveness
- ☐ Other: _____

If request is for a specific time period or program please specify:

Date From: _____ To: _____ Program: _____

Section E: Expiration

I understand that this authorization will expire within one year of the date of my signature below unless I specify another date/event here: _____

Section F: Other Information

I understand that: (1) the Highland Rivers Behavioral Health cannot guarantee that the recipient of this information will not re-disclose this information to a third party. The recipient may not be subject to federal laws governing privacy of health information. However, if the disclosure consists of treatment information about an individual in a substance use program, the recipient is prohibited under federal law from making any further disclosure of such information unless further disclosure is expressly permitted by written consent of the individual or as otherwise permitted by federal law governing confidentiality of substance use rehabilitation patient records (42 CFR, Part 2); (2) except where I am receiving health care solely for the purpose of creating information for disclosure to a third party, I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment from the Highland Rivers Behavioral Health; and (3) I may revoke this authorization in writing at any time, except that the revocation will not have any effect on any action taken by the Highland Rivers Behavioral Health in reliance on this authorization before written notice of revocation is received (See Notice of Privacy Practices).

Signature of Individual _____ Date _____ Time _____ AM/PM

Individual's Date of Birth: _____ Last 4 digits of Individual's Social Security Number: _____

* _____ _____ _____ AM/PM

Signature of Parent or Legal Representative (if applicable) Date Time

***Must Specify Relationship to Individual (Parent, Guardian, etc.)**

USE THIS SPACE ONLY IF INDIVIDUAL WITHDRAWS CONSENT

Date revoked by Individual: _____ Signature of Individual _____