

HONORABLE JUDGE JACK W. PULCHER

NUCECES COUNTY VETERANS TREATMENT COURT  
901 LEOPARD STE. 802  
CORPUS CHRISTI, TEXAS 78401  
361-888.0510

**VETERAN TO COMPLETE THE FOLLOWING CHECKLIST:**

**DD214 Member 4 Copy / Enlisted or Officer Record Brief / Military Service Records**

**VA Documents (Compensation & Benefits / Disability Rating/Pension Bring Breakdown Showing ALL DISABILITIES)**  
If not registered with local VA, view list attached on how to enroll

**Mental Health and/or substance abuse/dependence treatment records and/ or certificates (Military, VA, and Private Provider)**

**VTC Application (Answer ALL questions)**

**VJO Screening (contact Jenessis Shaw 361-800-2431)**

## **LOCAL VA ENROLLEMNT PROCESS:**

### **By Telephone**

The telephone application option is a more convenient way to apply for enrollment, and eliminates the need for a signed paper application.

- VA staff members will collect the needed information and process the enrollment application for an enrollment determination.
- To apply, call 1-877-222-VETS (8387), Mon-Fri between 8 am and 8 pm, EST.

### **Apply Online**

Fill out the application online and electronically submit it to VA for processing. No need for additional documents to verify military service. If you were recently discharged, we will get your military information for you.

- Click here to complete [the healthcare application](#) online.
- Once you complete the application, you may submit your application online.
- You will immediately receive a confirmation message notifying you that your application has been received.
- A signature is not required for online registration.
- For more information about the application process, [click here](#).
- You will also receive information about the appeals process, if you do not agree with the enrollment decision.

### **In Person**

Veteran can present to the clinic located at 205 S Enterprise Pkwy, Corpus Christi, TX 78405 (361) 939-6510 and fill out the necessary forms.

Phases are based on track and length of term in Veterans Treatment Court

### **PHASE ONE-RED (3-6 MONTHS)**

- VJO SCREENING
- MENTAL HEALTH EVALUATION + RECOMMENDATION
- SUBSTANCE ABUSE TREATMENT PROGRAM EVALUATION (OFFENSE RELATED EVAL)
- SET UP WITH PRIMARY CARE PHYSICIAN
- 2 UA'S A MONTH FOR 3 MONTHS
- MONTHLY HOME VISIT
- VET TO ATTEND STAFFING/PROBATION ONCE A MONTH & VTC DOCKET
- DEVICES MUST BE OBTAINED WITHIN 10 DAYS OF PLEA (OFFENSE RELATED)
- BIPP, ANGER MANAGEMENT AT VET CENTER
- MH COUNSELING SERVICE
- MUST NOT BE IN ARREARS BEFORE ADVANCEMENT TO NEXT PHASE

### **PHASE TWO-WHITE (4-9 MONTHS)**

- 1 RANDOM UA PER MONTH
- APPEAR FOR VETERANS TREATMENT COURT DOCKET
- CONSISTENCY & COMPLIANCE IN PROGRAMS & TREATMENT
- 1/2 CSR COMPLETED BEFORE ADVANCEMENT TO NEXT PHASE

### **PHASE THREE-BLUE**

- PROGRAMS COMPLETED
- REPORT QUARTERLY OR OTHERWISE DIRECTED
- RANDOM UA'S
- CONTINUED ENGAGEMENT W/ VA & MH SERVICES
- COMPLETION OF CSR HOURS

## NUECES COUNTY VETERANS COURT- INITIAL APPLICATION

Please fill out this application completely. Applicants must additionally complete a VA 10-5345 form and provide a DD214. Your application is not complete without each of these documents.

### Applicant Information

Name:

Date of Birth:

SSN:

Phone:

Current Address:

City:

State:

ZIP Code:

Email Address:

Defense Attorney:

### Applicant Employment Information

Current Employer:

Employer Address:

How Long?

Phone No:

Position:

Annual Income:

### Applicant Pending Criminal Charges

Criminal Charge:

Court:

Criminal Charge:

Court:

Criminal Charge:

Court:

### Applicant Criminal History

Please list prior felony

convictions: \_\_\_\_\_

Please list prior misdemeanor  
convictions: \_\_\_\_\_

### Applicant Military Background

Branch:	Rank:	Grade:	Circle One: Active      Reserve
Start Date:	End Date:	Discharge Type:	Guard

Combat/Hazardous Duty Deployments: \_\_\_\_\_

Military Occupational Specialty

(MOS): \_\_\_\_\_

Education Level/Degrees \_\_\_\_\_

Awards, Decorations and/or Award Citations \_\_\_\_\_

List any Mental Health or Substance Abuse Programs previously completed \_\_\_\_\_

### Applicant Military Service Related Disability Background

List Military Service Connected Disabilities:

List any Rehabilitation or Other Recovery Programs:

Veterans Administration (VA) Disability Rating:

**Legal Warning**

I authorize the Nueces County Veterans Court staff to verify the information provided on this form, including my military, criminal and employment history. I understand I will need to provide all the documents listed in the application requirements to complete my initial application. I further understand that other forms may be presented to me or my attorney and that those forms must be completed in order for me to participate in Veterans Treatment Court. I HEREBY SWEAR AND AFFIRM that I am currently an active duty member of the United States military OR that I have received an honorable discharge or general discharge from United States military service. I further HEREBY SWEAR AND AFFIRM that my military background, Social Security Number and all other information I have added to this form is valid and correct. I understand that making a false statement on this form is a violation of the laws of the State of Texas that may be prosecuted as a separate criminal offense.

Signature of Applicant:	Date:
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## REQUEST FOR AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

**PRIVACY ACT INFORMATION:** 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 the information including the last four of your Social Security Number (SSN) and Date of Birth (used 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 treatment, payment, enrollment or eligibility on signing the authorization. VA may disclose the information that you put on the form as permitted by law. VHA may make a "routine use" disclosure of the information as outlined in the Privacy Act system of records notices identified as 24VA10P2 "Patient Medical Record - VA" and in accordance with the VHA Notice of Privacy Practices. 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.

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

VHA Valley Coastal Bend  
5227 Old Brownsville Road  
Corpus Christi, TX 78405

LAST NAME- FIRST NAME- MIDDLE INITIAL	LAST 4 SSN	DATE OF BIRTH
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NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL, OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

Court Judge, ADA, defense attorney, Jail infirmary and/or diversion, VSO, other VJO coordinators, Community-based service providers (as needed), County probation, VTC staff

### 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 includes information regarding the following condition(s):

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

### DESCRIPTION OF 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*): \_\_\_\_\_  
     SPECIFIC PROVIDERS (*Name & Date Range*): \_\_\_\_\_  
     DATE RANGE: \_\_\_\_\_  
 OPERATIVE/CLINICAL PROCEDURES (*Name & Date*): \_\_\_\_\_  
 LAB RESULTS:  
     SPECIFIC TESTS (*Name & Date*): \_\_\_\_\_  
     DATE RANGE: \_\_\_\_\_  
 RADIOLOGY REPORTS (*Name & Date*): \_\_\_\_\_  
 LIST OF ACTIVE MEDICATIONS \_\_\_\_\_  
 OTHER (*Describe*): Service-connected disabilities, DD214 information

### PURPOSE(S) OR NEED

Information is to be used by the individual for:

TREATMENT  BENEFITS  LEGAL  OTHER (*Specify below*)

LAST NAME- FIRST NAME- MIDDLE INITIAL		LAST 4 SSN	DATE OF BIRTH
<b>AUTHORIZATION</b>			
<p>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.</p>			
<p>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.</p>			
<b>EXPIRATION</b>			
<p>Without my express revocation, the authorization will automatically expire.</p>			
<p><input checked="" type="checkbox"/> UPON SATISFACTION OF THE NEED FOR DISCLOSURE</p>			
<p><input type="checkbox"/> ON _____ <i>(enter a future date other than date signed by patient)</i></p>			
<p><input type="checkbox"/> UNDER THE FOLLOWING CONDITION(S): _____</p>			
PATIENT SIGNATURE <i>(Sign in ink)</i>		DATE <i>(mm/dd/yyyy)</i>	
LEGAL REPRESENTATIVE SIGNATURE <i>(if applicable)</i> <i>(Sign in ink)</i>		DATE <i>(mm/dd/yyyy)</i>	
PRINT NAME OF LEGAL REPRESENTATIVE		RELATIONSHIP TO PATIENT	
<b>FOR VA USE ONLY</b>			
TYPE AND EXTENT OF MATERIAL RELEASED			
DATE RELEASED		RELEASED BY:	