Orange County Veterans Court Referral Form

JUDGE_____ **DIV.**____

Track I – Diversion ___ Track II - Post Plea ____ Track III – VOP/COP ____

Final Track subject to approval of Veterans Court

CLIENT NFORMATION

Full Legal Name: _____

A/K/A: _____

Date of Birth: _____ Race: _____Gender: _____ SSN:_____

Marital Status: Single ___ Married ___ Divorced ___ Widowed____

Number and ages of children: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (____)_____Cell Phone/Other: (____)_____

If homeless, how long?_____

Lives With/Relationship: _____

Emergency Contact/Relationship: _____

Home Phone: (____)_____Cell Phone/Other: (____)_____

Currently in Custody? Y ____ N____ Inmate # _____

Employment: Full-Time _____ Part-Time _____Unemployed, Looking _____ Unemployed, Not Looking____

MILITARY SERVICE

Branch of Service:

Army ___ Navy ___ Marines ___ Air Force ___ Coast Guard ___ Reserve ___ Air National Guard___

Army National Guard____ Rank at discharge_____

Job(s) performed/MOS_____

Dates of Service: From _____ To _____

Type of Discharge: _____Have you been exposed to military combat? Y___ N___

If yes, number of deployments:___ and Conflicts?_____

Do you receive services from the US Department of Veterans Affairs? Y____ N_____

Do you have a copy of your DD214: Y____ N_____

CRIMINAL INFORMATION

Attorney Name: _____ Phone: (____) _____

Attorney E-mail Address: _____

Current Charge(s): _____ Case No: _____

_____ Case No: _____

Assistant State Attorney: _____

DUI Case - Accident : Y____ N____

If yes, Insurance Information: _____

Has client ever been arrested for a violent felony and/or sex crime? Y____ N____

Is client subject to a Protective Order? Y____ N____ Is client currently on probation or parole? Y____ N____

If yes, Probation/Parole Officer's name: _____

(Attach continuation sheet if necessary)

CLIENT WAIVER INFORMATION

I wish to apply to the Orange County Veterans Court.

_____ _____

Defendant/Client Signature **Date**

DO NOT WRITE BELOW THIS SECTION (VETERANS COURT OFFICIAL USE ONLY)

CRIMINAL HISTORY CHECK:

LOCAL:____ FCIC: ____ NCIC: ____ Verified by: ____ Notes: _____

DEFENDANT VA ELIGIBILITY REVIEW:

VA: Eligible for services (Y/N) _____ **Notes:** _____

STATE ATTORNEY'S OFFICE REVIEW:

Please circle one: Approved or Denied

Diversion: ____ Post Plea: ____ VOP/COP: ____ Sentencing Score: _____

Comments: _____

_____

_____

_____

_____

_____

OMB Number: 2900-0260
Estimated Burden: 2 minutes

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE MEDICAL RECORDS OR HEALTH INFORMATION

Privacy Act and Paperwork Reduction 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 Social Security Number (SSN) (the SSN will be used to locate records for release) is not furnished completely and accurately, Department of Veterans Affairs 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. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act systems of records notices identified as 24VA10P2 "Patient Medical Record - VA" and in accordance with the Notice of Privacy Practices. You do not have to provide the information to VA, but if you don't, VA will be unable to process your request and serve your medical needs. Failure to furnish the information will not have any affect 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. 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 2 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

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

TO: DEPARTMENT OF VETERANS AFFAIRS (Print or type name and address of health care facility)

Orlando VA Medical Center
5201 Raymond Street, Orlando, FL 32803

PATIENT NAME (Last, First, Middle Initial)

SOCIAL SECURITY NUMBER

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

Ninth Judicial Court, Veterans Court Team Members
425 North Orange Avenue, Orlando, Florida 32801

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 ☒ 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 (Specify)

VA Eligibility, Medical and Mental Health Diagnosis, including prescribed medications previous treatment and outcomes related to psychiatric and substance abuse related issues

PURPOSE(S) OR NEED FOR WHICH THE INFORMATION IS TO BE USED BY INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

Legal/Court related issues/Post Release/Re-entry Planning/Jail Diversion.

NOTE: ADDITIONAL ITEMS OF INFORMATION DESIRED MAY BE LISTED ON THE BACK OF THIS FORM

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing the records. Redisclosure of my medical records by those receiving the above authorized information may be accomplished without my further written authorization and may no longer be protected. Without my express revocation, the authorization will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on _____ (date supplied by patient); (3) under the following condition(s):

Upon Resolution of Legal/Court Related Issues

I understand that the VA health care practitioner'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.

DATE (mm/dd/yyyy)

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

FOR VA USE ONLY

IMPRINT PATIENT DATA CARD (or enter Name, Address, Social Security Number)

TYPE AND EXTENT OF MATERIAL RELEASED

DATE RELEASED

RELEASED BY

OMB Number: 2900-0260
Estimated Burden: 2 minutes

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE MEDICAL RECORDS OR HEALTH INFORMATION

Privacy Act and Paperwork Reduction 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 Social Security Number (SSN) (the SSN will be used to locate records for release) is not furnished completely and accurately, Department of Veterans Affairs 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. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act systems of records notices identified as 24VA19 "Patient Medical Record - VA" and in accordance with the VHA Notice of Privacy Practices. You do not have to provide the information to VA, but if you don't, VA will be unable to process your request and serve your medical needs. Failure to furnish the information will not have any affect 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. 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 2 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

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

TO: DEPARTMENT OF VETERANS AFFAIRS (Print or type name and address of health care facility)	PATIENT NAME (Last, First, Middle Initial)
Orlando VA Medical Center 5201 Raymond St., Orlando, FL 32803	SOCIAL SECURITY NUMBER

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

Orange County Veterans Court (OCVC) judge, staff, and attorneys; guests of OCVC not directly involved with court-directed treatment

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 ☐ 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 (Specify)

All medical records and health information, past and future, related to court-directed treatment

PURPOSE(S) OR NEED FOR WHICH THE INFORMATION IS TO BE USED BY INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

To provide OCVC with a current status of treatment, which will require records created after the signature of this authorization and to provide training to the guests of OCVC

NOTE: ADDITIONAL ITEMS OF INFORMATION DESIRED MAY BE LISTED ON THE BACK OF THIS FORM

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing the records. Redisclosure of my medical records by those receiving the above authorized information may be accomplished without my further written authorization and may no longer be protected. Without my express revocation, the authorization will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on _____ (date supplied by patient); (3) under the following condition(s):

I understand that the VA health care practitioner'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.

DATE (mm/dd/yyyy)	SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO SIGN FOR PATIENT (Attach authority to sign, e.g., POA)

FOR VA USE ONLY

IMPRINT PATIENT DATA CARD (or enter Name, Address, Social Security Number)	TYPE AND EXTENT OF MATERIAL RELEASED	
	DATE RELEASED	RELEASED BY

VA FORM MAY 2005 **10-5345** USE EXISTING STOCK OF VA FORM 10-5345, DATED NOV 2004

OPTIONAL (COVERS GUESTS AT STAFFING SESSIONS)

Standard Form 180 (Rev. 5/12) (Page 1)
Prescribed by NARA (36 CFR 1228.168(b))
Authorized for local reproduction
Previous edition unusable
OMB No. 3095-0029 Expires 01/31/2015

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 clearly or type.)

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

1. NAME USED DURING SERVICE (last, first, and middle)	2. SOCIAL SECURITY NO.	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 COMPONENT						
b. RESERVE COMPONENT						
c. NATIONAL GUARD						

6. IS THIS PERSON DECEASED? If "YES" enter the date of death.
[x] NO [ ] YES _____

7. IS (WAS) THIS PERSON RETIRED FROM MILITARY SERVICE?
[ ] NO [ ] YES

SECTION II – INFORMATION AND/OR DOCUMENTS REQUESTED

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

[x] **DD Form 214 or equivalent.** When was the DD Form(s) 214 issued? YEAR(S): _____
If more than one period of service was performed, even in the same branch, there may be more than one DD214.

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.** Sensitive items, such as, the character of separation, authority for separation, reason for separation, reenlistment eligibility code, separation (SPD/SPN) code, and dates of time lost are usually shown.

An undeleted copy will be sent unless you specify a deleted copy. Indicate here if you want a deleted copy of the DD Form 214 . [ ].

The following items are deleted: 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.

[ ] **All Documents in Official Military Personnel File (OMPF)**

[ ] **Medical Records** (Includes Service Treatment Records, Health (outpatient) and dental records.) If hospitalized (inpatient), the facility name and date for each admission **must** be provided: _____

[ ] **Other** (Specify): _____

2. **PURPOSE:** (An explanation of the purpose of the request is **strictly voluntary**; however, such information 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.) Check appropriate box:

[ ] Benefits [ ] Employment [ ] VA Loan Programs [ ] Medical [ ] Genealogy [ ] Correction [ ] Personal
[ ] Other, explain: _____

SECTION III - RETURN ADDRESS AND SIGNATURE

1. **REQUESTER IS:** (*Signature Required in # 3 below of veteran, next of kin, legal guardian, authorized government agent or "other" authorized representative. If "other" authorized representative, provide copy of authorization letter.) No signature required for Archival records.*

[x] Military service member or veteran identified in Section I, above
[ ] Next of kin of deceased veteran: _____ *(Relationship)*
[ ] Legal guardian (Must submit copy of court appointment.)
[ ] Other (specify) _____

MUST HAVE PROOF OF DEATH - See item 2a on instruction sheet.

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

Orange County Veterans Court
Name

425 North Orange Avenue
Street Apt.

Orlando FL 32801
City State Zip Code

3. **AUTHORIZATION SIGNATURE WHEN REQUIRED** *(See items 2a or 3a on accompanying instructions.)* 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. No signature required for Archival records.

Signature Required - Do not print **Date**

(407) 836-0651 (407) 835-5006
Daytime phone Fax Number

ctaddr3@ocnjcc.org
Email address

*This form is available at *http://www.archives.gov/research/order/standard-form-180.pdf* on the National Archives and Records Administration (NARA) web site.*