

To qualify for VTC, a defendant must:

- Be charged with a criminal offense in Galveston County
- Be a US military Veteran, on Active Duty, or serve in the Reserves, National Guard or State Guard
- Be Active Duty or be discharged under Honorable or General Under Honorable conditions
- Be a resident of Galveston County or a county adjoining Galveston County
- The commission of the charged criminal offense must be related to a mental health illness, post – traumatic stress disorder, or traumatic brain injury suffered due to military service

All applicants are reviewed on a case by case basis and not all criminal charges will be considered for Veterans Treatment Court. Many factors, including prior convictions are considered,

The VTC program is voluntary and involves at least twelve (12) months of treatment. VTC can be either a probation program or a pre-trial program. Many factors are considered in determining which program will be offered to an applicant. Applicants will be told which program the applicant qualifies for before the applicant formally agrees to placement into VTC.

There is a standard VTC supervision fee of up to \$1,000. Participants may also be required to pay for substance abuse testing equipment.

Applicants are required to submit to an evaluation by the Department of Veterans Affairs which will be reviewed by the Veterans Treatment Court staffing committee.

Participants are required to comply with Veterans Treatment Court agreement conditions in order to remain in the program. Participants are given access to appointed defense counsel for the duration of the Veterans Treatment Court proceedings.

The Presiding Judge of the trial court makes the final determination regarding whether or not an applicant is able to participate in the Veterans Treatment Court program. Any participant who withdraws, is removed, or otherwise cannot complete the program will resume regular docket activity with the trial court.

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If you believe you are a qualifying Veteran and would like to apply to the VTC program, please notify Court Staff, Jail personnel or a Galveston County Veterans Service Officer immediately.

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The Galveston County Veterans Treatment Court is a non-adversarial treatment program. Veterans accepted into the program have their cases administratively transferred to Veterans Treatment Court for the duration of treatment proceedings; however, the case remains under the jurisdiction of the District Court or County Court at law in which the case was originally assigned.

The Galveston County Veterans Treatment Court does not discriminate based on race, ethnicity, religion, gender, disability, or age in the delivery services.

If you would like to know more about Veterans Treatment Court or services offered for Veterans in general, please call the Galveston County Veterans Services at (409)-766-2448.

Galveston County Veterans Treatment Court (VTC)

MISSION STATEMENT

The mission of the Galveston County Veterans Treatment Court is to assist Veterans and their families to become integral and productive members of the community through a collaborative effort, and to honor them and restore their dignity for their selfless service to our country; we shall leave no Veteran behind.



Initial Application, Description of Eligibility and Program Requirements

Galveston County Veteran Treatment Court- Initial Application

Please fill out this application completely. Applicant must additionally complete a VA 10-5345 form.

APPLICANTS PERSONAL INFORMATION

NAME: _____
DATE OF BIRTH: _____ SSN: _____ PHONE: _____
CURRENT STREET ADDRESS: _____
CITY: _____ STATE: _____ ZIP CODE: _____
EMAIL: _____ DEFENSE ATTORNEY: _____

APPLICANTS EMPLOYMENT INFORMATION

CURRENT EMPLOYER: _____
LOCATION OF EMPLOYER (CITY&STATE): _____ ANNUAL INCOME: _____
POSITION: _____ LENGTH OF EMPLOYMENT: _____

APPLICANTS PENDING CHARGES

CRIMINAL CHARGE: _____ COURT: _____
CRIMINAL CHARGE: _____ COURT: _____
CRIMINAL CHARGE: _____ COURT: _____

APPLICANTS CRIMINAL HISTORY

PLEASE LIST PRIOR FELONY CONVICTIONS:

PLEASE LIST PRIOR MISDEMEANOR CONVICTIONS:

APPLICANTS MILITARY BACKGROUND

BRANCH: _____ RANK: _____ GRADE: _____ CIRCLE: ACTIVE RESERVE GUARD
ENTRY DATE: _____ END DATE: _____ DISCHARGE TYPE: _____
COMBAT/HAZARDOUS DUTY DEPLOYMENTS: _____
MILITARY OCCUPATIONAL SPECIALITY (MOS): _____

APPLICANTS MILITARY SERVICE RELATED DISABILITY BACKGROUND

LIST MILITARY SERVICE CONNECTED DISABILITIES: _____
LIST ANY REHABILITATION OR OTHER RECOVERY PROGRAM: _____
VETERAN ADMINISTRATION DISABILITY RATING: _____

LEGAL WARNING

I authorize the Galveston County Veteran Treatment court staff to verify the information provided on this form, including my military, criminal and employment history. I understand I will need to fill out a VA 10-5345 form in addition to this application 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 the 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: _____



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 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. 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)
MEDVAMC 2002 Holcombe Blvd. Houston, TX 77030	
	SOCIAL SECURITY NUMBER

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

Galveston County Veterans Court
600 59th Street Galveston, TX 77551 (409)-766-2448

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)

Communicate via telephone or fax the eligibility status of Veteran to receive services at VHA locations, enrollment status and any available military history and service connection. Communication through e-mail is also authorized.

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

For the purpose of establishing eligibility status for the Galveston County Veterans Court Program,

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):

PART ONE: Authorization to Disclose Eligibility for Treatment

Upon satisfaction of the need for disclosure.

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) (Sign in ink)

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



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 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. 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)
MEDVAMC 2002 Holcombe Blvd. Houston, TX 77030	
	SOCIAL SECURITY NUMBER

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

Galveston Veterans Court Staff, all affiliated agencies, attorneys, and training guests
 600 59th Street Galveston, TX 77551 (409)-766-2448

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)

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

For the purpose of assessing compliance in court-monitored treatment program and to train visiting guests in court staffing processes.

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):

PART TWO: Authorization to disclose Psycho/Social Evaluation

Upon completion of court ordered program not to exceed four years from the date of the signature below.

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) (Sign in ink)

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