



If your client meets **any** of the following EXCLUSIONARY criteria, the application will not be processed.

- 4. Be a violent offender by Federal definition.

**Wis. Stat. § 165.95 Alternatives to incarceration; grant program.**

**(1) In this section, "violent offender" means a person to whom one of the following applies:**

**(a) The person has been charged with or convicted of an offense in a pending case and, during the course of the offense, the person carried, possessed, or used a dangerous weapon, the person used force against another person, or a person died or suffered serious bodily harm.**

**(b) The person has one or more prior convictions for a felony involving the use or attempted use of force against another person with the intent to cause death or serious bodily harm.**

**\*\*\*All final decisions are made by the Manitowoc County Drug Court Team\*\*\***

APPLICANT INFORMATION:

Contact Phone #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_

Race: \_\_\_\_\_ Hispanic? YES NO Gender Identity: \_\_\_\_\_

Primary Language: \_\_\_\_\_ Interpreter needed? YES NO Marital Status: \_\_\_\_\_

Highest Level of Education: \_\_\_\_\_ High School Graduate? YES NO

Employment Status (include shift/work hours): \_\_\_\_\_

How many months have you been employed full-time in the past year? \_\_\_\_\_

Are you a Veteran? YES NO If yes, Dates Served: \_\_\_\_\_ Branch: \_\_\_\_\_

Discharge: \_\_\_\_\_

Do you have a valid driver's license? YES NO

Insurance: \_\_\_\_\_ Guarantor/Relationship: \_\_\_\_\_

Do you have any children? YES NO If yes, please provide ages: \_\_\_\_\_

Type of Housing: \_\_\_\_\_ How long have you lived in Manitowoc? \_\_\_\_\_

How many times have you moved in the last 6 months? \_\_\_\_\_

Who do you live with currently? (include name and relationship to you):

\_\_\_\_\_  
Name Relationship to you

\_\_\_\_\_  
Name Relationship to you

\_\_\_\_\_  
Name Relationship to you

\_\_\_\_\_  
Name Relationship to you

Name \_\_\_\_\_

Relationship to you \_\_\_\_\_

Previous or current AODA Treatment (e.g. detox, residential, outpatient)

Location	Provider Name	Approximate Dates
_____	_____	_____
_____	_____	_____
_____	_____	_____

Previous or current Mental Health Treatment (e.g. hospitalization, residential, outpatient):

Location	Provider Name	Approximate Dates
_____	_____	_____
_____	_____	_____

Date of arrest (if applicable): \_\_\_\_\_

Current/Pending Charges: \_\_\_\_\_

Case Number and Branch: \_\_\_\_\_

Next Scheduled Court Date: \_\_\_\_\_

Type of Hearing (Pre-Trial, Trial Sentencing): \_\_\_\_\_

Supervision Status: \_\_\_\_\_ Agent: \_\_\_\_\_

List any general health concerns: \_\_\_\_\_

### CRITERIA FOR PARTICIPATION

**I understand that I will be required to submit to/complete the following requirements if I am accepted into Drug Court and have acknowledged my understanding by initialing each requirement below.**

- \_\_\_\_ 1. Remain alcohol/drug free.
- \_\_\_\_ 2. Submit to random, observed urine screens and/or any recommended toxicology testing at least 3 times per week.
- \_\_\_\_ 3. Attend treatment per assessment and treatment plan specifications.
- \_\_\_\_ 4. Attend at least 3 self-help meetings per week.
- \_\_\_\_ 5. Appear in Drug Court at scheduled appearance times (Wednesdays at 9:00 am).
- \_\_\_\_ 6. Meet with case manager at least 1 time per week or as recommended.

\_\_\_\_ 7. Meet with Probation Agent as scheduled based on Phase of the program.

\_\_\_\_ 8. I understand that the frequency of some of the requirements might be increased should it be in the best interest of my rehabilitation.

**\*Upon acceptance into the Drug Court program, a complete list of the rules and expectations will be provided. \***

ESSAYS/Applicant;

1. Explain your reasons for wanting to participate in Treatment Court at this time. (Write clearly)

I, \_\_\_\_\_, understand and agree that if I am accepted into the Manitowoc County Treatment Court Program, I will comply with the Treatment Court Conditions/Terms of Participation. Upon sentencing, I must agree to a length of probation of **at least** 24 months; I must sign all Releases of Information, as requested by the Treatment Court. If I am not accepted into the program, the information in this application may **NOT** be used against me in any criminal or revocation proceeding.

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Signature of Participant

Date

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Counsel or Referent for Participant/**Print Name**

Signature

Date

Mailing Address and Contact # for Defendant's Counsel

Contact #: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PLEASE COMPLETE ALL AUTHORIZATIONS TO RELEASE INFORMATION & SEND WITH APPLICATION**

**For Office Use Only:**

**Accepted: Y N**      **Date:** \_\_\_\_\_

**Denial Reason:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_