State of Florida

Thirteenth Judicial Circuit

Adult Drug Treatment Court Program Application

CONFIDENTIAL INFORMATION TO BE DISCLOSED
SOLELY FOR THE PURPOSE OF APPLYING AND PARTICIPATING
IN THE ADULT DRUG TREATMENT COURT PROGRAM

Submit application to the Administrative Office of the Courts/Adult Drug Treatment Court Program:
AdultDrugTreatmentCourtProgramReferral@fljud13.org

For questions, please contact the Adult Drug Treatment Court Program Office at (813) 307-3356

Thirteenth Judicial Circuit • 800 E. Twiggs Street, Tampa, Florida 33602 · www.fljud13.org

(Revised: 20260101)

ADULT DRUG TREATMENT COURT PROGRAM APPLICATION

Thirteenth Judicial Circuit

Date:		**Case Number(s):**									
Last Name:		**First Name**:						**MI**:			
Date of Birth:		**Age:**		**Gender**:	☐ M	☐ F	☐ Transgender				
Race:	American Indian or Alaska Native ☐	Asian ☐	Black ☐	Native Hawaiian ☐	White ☐	Last 4# of SSN:					
Address:		**Phone Number:**		**Homeless (√):** ☐							
City:		**State:**		**Zip Code:**		**Email:**					
Collateral Contact One Name:				**Relationship:**							
Phone Number:				**Email:**							
Collateral Contact Two Name:				**Relationship:**							
Phone Number:				**Email:**							
Is English your primary language spoken?	☐ Yes ☐ No	If no, please list language:									
Do you require the use of an interpreter?	☐ Yes ☐ No										
Have you had previous substance use treatment?	☐ Yes ☐ No	If yes, where:									
Have you had previous mental health treatment?	☐ Yes ☐ No	If yes, where:									
Have you previously participated in Drug Court?	☐ Yes ☐ No										
If yes, what was the disposition?											
Are you currently employed?	☐ Yes ☐ No	**Employer:**									
		☐ Full Time ☐ Part Time ☐ Other:									
Have you have been diagnosed with any of the following?											
Traumatic Brain Injury	☐ Yes ☐ No	If yes, explain:									
Mental Health Diagnosis	☐ Yes ☐ No	If yes, explain:									
Developmental Disabilities	☐ Yes ☐ No	If yes, explain:									
Do you have a history of suicide attempts?	☐ Yes ☐ No										
Are you currently prescribed any of the following medications?	☐ Yes ☐ No										
(If yes, please select [√] any of the drugs that are prescribed below)											
Abilify ☐	Adderal ☐	Ambien ☐	Flexeril ☐	Hydrocodone ☐	Klonopin ☐	Lithium ☐					
Mirtazapine ☐	Morphine ☐	Methadone ☐	Oxycodone ☐	Provigil ☐	Prozac ☐	Ritalin ☐					
Seroquel ☐	Soma ☐	Suboxone ☐	Temazepam ☐	Tramadol ☐	Trazodone ☐	Valium ☐					
Xanax ☐	Zoloft ☐	Other Drugs:									

Drugs of choice category: Please select [√] substances of abuse												
Acid/LSD	☐	Alcohol	☐	Benzodiazepine	☐	Cocaine	☐	Ecstasy/MDMA/Molly	☐			
Heroin	☐	Inhalants	☐	K2/Synthetic Marijuana	☐	Marijuana	☐	Methamphetamine	☐			
Opiates	☐	PCP	☐	Prescription Medications	☐	Steroids	☐	Tobacco Dependence	☐			
Suboxone	☐	Soma	☐	Methadone	☐	Tramadol	☐	Other:				
Age began using drugs?					**Age began using alcohol?**							
Associated with support group(s)?		☐ Yes ☐ No			Name of group(s)							
Have you ever been convicted of the following crimes?												
Arson		☐ Yes ☐ No			Murder		☐ Yes ☐ No					
Any Sexual Offense		☐ Yes ☐ No			Forcible Felony		☐ Yes ☐ No					
Drug Dealing or Trafficking?		☐ Yes ☐ No			Do You Have a Drug Problem?		☐ Yes ☐ No					
What are the points on your current Criminal Punishment Code Scoresheet?												
What lettered division were you in before?												
Have you ever been in the military?		☐ Yes ☐ No										
Are you currently Pregnant?		☐ Yes ☐ No ☐ N/A										
Are you agreeable to participate in any level of drug treatment as ordered by the court?							☐ Yes ☐ No					

Attorney's Name: _____ **Attorney's Phone Number:** (____) _____- _____

Attorney's Email: _____

Note to Attorney: Please submit a copy of the applicant's current Criminal Punishment Code Scoresheet along with the signed Authorization for Disclosure of Confidential Information (below) to the Adult Drug Treatment Court Program Office.

ADMINISTRATIVE OFFICE OF THE COURTS
THIRTEENTH JUDICIAL CIRCUIT

Adult Drug Treatment Court Program Office
801 E. Twiggs Street, Room 608
Tampa, Florida 33602

Drug Court Specialist II **Fax: 813-301-3819**

AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

I, _____ **DOB:** _____
(Applicant's Full Name)

hereby authorize the Administrative Office of the Courts to communicate, receive, disclose, and exchange my information with the following individuals, offices, and agencies as necessary and appropriate in connection with my case:

**** PLEASE CHECK EACH BOX AS APPLICABLE ****

- ☐ Public Defender's Office
- ☐ Private Attorney's Office
- ☐ State Attorney's Office
- ☐ Problem-Solving Court Staff
- ☐ Problem-Solving Court Judge
- ☐ Tri County Human Services
- ☐ Phoenix House
- ☐ Operation PAR
- ☐ Westcare
- ☐ Centerstone
- ☐ Riverside Recovery
- ☐ Naphcare (HCJ Medical Records)
- ☐ Veterans Administration (VA Medical Records)
- ☐ Salvation Army
- ☐ Turning Point of Tampa
- ☐ Department of Corrections
- ☐ IBIS - Cove
- ☐ IBIS - Gracepoint
- ☐ ACTS
- ☐ Selah Freedom
- ☐ Sober Solutions Counseling
- ☐ First Step of Sarasota
- ☐ Other: _____

Purpose for the Disclosure: To assist me in completing requirements for the offices, agencies, and treatment providers designated above and successfully completing drug offender probation including requirements of the problem-solving court.

To communicate, receive, disclose, and exchange the following information as necessary and appropriate in connection with my case:

- ☐ All my substance abuse and mental health treatment records
- ☐ All my medication administration records

Information may be disclosed by the following methods: verbal, mail, fax, and encrypted email, unless otherwise specified below:

_____

I understand that my records are protected under the Federal and State regulations governing the confidentiality and privacy of medical records and protected alcohol and drug abuse health information under 42 C.F.R., Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") 45 C.F.R., Parts 160 and 164 and cannot be disclosed without my written authorization unless otherwise provided for by the regulations. I understand that I have a right to request a copy of this form.

I also understand that I may revoke this authorization in writing at any time except to the extent that action has already been taken in reliance on it, and that in any event this authorization expires automatically after one year, unless otherwise stated below:

Date, event, or condition of expiration: Upon Case Closure

Executed this _____day of _____, 20 _____.

Signature of Applicant: _____

Signature of Witness: _____

This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.