TREATMENT COURT OF SWEETWATER COUNTY

REQUEST FOR ADMISSION AND

INFORMATIONAL INTAKE FORM

Please fill out INTAKE completely: Today's Date:_____

FULL NAME: _____ Age: _____

DOB:_____SS#:_____Gender:_____

TELEPHONE NUMBERS: _____

ADDRESS (where you will be living): _____

_____

_____

Place of Birth:_____Are you a U.S. citizen. **YES/NO**

IDENTIFIERS:

EYE COLOR: _____HAIR COLOR: _____HEIGHT/WEIGHT: _____

ETHNICITY: _____

TATTOOS/SCARS/MARKS/PIERCINGS: _____

_____

_____

How long have you lived in this area?_____ Do you plan to stay in this area?_____

What are your connections to Sweetwater County?_____

_____

How many times have you moved in the last year? _____

Have you been homeless within your lifetime?_____

CURRENT OFFENSE: _____

DATE OF CURRENT OFFENSE:_____ PLEA: _____

JUDGE: _____

COUNTY ATTORNEY: _____

DEFENSE ATTORNEY: _____

IMPORTANT: List any charges in any other court or jurisdiction that is not resolved.

_____

EDUCATION:

Highest Grade Level Completed: _____ Name of School: _____
Did you receive a Diploma? _____ GED?_____ What Year? _____
Continued Education, certificates or specialized training:_____
If you discontinued school, when did you quit and why?_____
Ever suspended or expelled from school? _____

EMPLOYMENT:

Are you currently employed: _____
How many months have you worked in the past year? _____
Present Employer: _____ What do you make per hour? _____
Longest job you had: _____
Date started: _____ Position: _____
Previous Employer:
Dates Employed: _____ Position: _____
Reason for employment ending: _____

SPOUSE/SIGNIFICANT OTHER:

Name: _____ Address: _____
Telephone number: _____ Birthdate: _____
Occupation: _____
If married, how long? _____
If living together, how long? _____
If divorced or separated, how long? _____
Do they consume alcohol or use illicit drugs? _____
What, frequency, amounts: _____
Have they ever received addiction treatment?_____
Where/When : _____
Have they ever been abusive to you/others?_____
Have they ever been incarcerated for 30 days or more? _____
For what? _____
How is your relationship currently? _____

PRIOR RELATIONSHIPS OR MARRIAGES:

How many prior marriages and significant relationships:_____

To Whom:_____Date of Relationship Began/Ended: _____

To Whom:_____Date of Relationship Began/Ended: _____

To Whom:_____Date of Relationship Began/Ended: _____

Reason for Relationships ending:_____

_____

DO YOU LIVE WITH SOMEONE OTHER THAN A SPOUSE OF SIGNIFIGANT OTHER? (Parents, relatives, roommate) Please list name(s):

_____

Phone number(s): _____Ages: _____

Is that person or anyone in your household on probation or parole? _____

If so, for what? _____

Does anyone in this household use alcohol or illicit drugs? **YES/NO**

How long have you lived with this person(s). _____

Where did you reside before that and for how long? _____

HOW MANY CHILDREN DO YOU HAVE: _____

Name: _____Date of Birth: _____Address: _____

Name: _____Date of Birth: _____Address: _____

Name: _____Date of Birth: _____Address: _____

Name: _____Date of Birth: _____Address: _____

Who has custody of the above listed children?

_____

How many children live with you?

_____

Name(s) children residing with you?

_____

EMERGENCY CONTACT: name, address, phone number, relationship:

_____

_____

_____

_____

PARENTS:

Father: _____ Date of Birth: _____ Address: _____
Mother: _____ Date of Birth: _____ Address: _____
Step-Father: _____ Date of Birth: _____ Address: _____
Step-Mother: _____ Date of Birth: _____ Address: _____

How is your relationship with your mother? _____
How is your relationship with your father? _____
Were you neglected or abused as a child? **YES/NO (Emotional, Psychological, Physical, Neglect)**

SIBLINGS:

Name: _____ Date of Birth: _____ Address: _____
Name: _____ Date of Birth: _____ Address: _____
Name: _____ Date of Birth: _____ Address: _____
Name: _____ Date of Birth: _____ Address: _____
Do any of them currently have problems with Drugs or Alcohol?

_____

Do any of them have current or past legal problems?

_____

Have any of them had previous problems with Drugs or Alcohol?

_____

How is your relationship with your siblings?

_____

TRANSPORTATION

It is a requirement of the Treatment Program that you have reliable transportation to and from treatment, to and from probation, to and from court, to and from self-help meetings. Please indicate what your plans are for reliable transportation while in the Treatment Program:

Do you own a vehicle? _____ Do you have insurance? _____
Name of Insurance Company: _____
Do you have a valid driver's license? _____
License Number: _____
Describe the vehicles you drive: (make, model, year, color, license plate number) Primary vehicle: _____

_____

If you do not have a valid driver's license or vehicle, what is your plan for transportation:_____

_____

_____

_____

PRIOR CRIMINAL HISTORY:

Age of first arrest? _____ What was the arrest for?_____

Total criminal convictions in your life: Juvenile:_____Adult:_____

Have you ever been charged with a violent crime? **YES / NO**
Please explain the violent charge:

_____

List prior offense history and the disposition (sentence you received) for each offense and include your current offense. In addition, please list date, city and state of past offenses.

_____

_____

_____

_____

_____

Any escape charges: _____
Have you had any additional disciplinary actions while incarcerated? _____

If so, explain: _____

_____

_____

How much jail/prison time is likely for the crime you are being charged with? _____

Have you previously been on probation?_____Has your probation ever been revoked?_____

List date, type of probation/parole (supervised/unsupervised:

_____

_____

_____

_____

Have you ever been in a correctional facility before? **YES / NO** List when, where, amount of time in custody:

_____

_____

_____

_____

_____

HEALTH:

Are you in good health?_____ When was your last Physical?_____

Do you have vision problems? _____ Do you have dental problems? _____

List any current prescribed medications and for what they are prescribed:

_____

_____

_____

_____

_____

_____

_____

List disabilities, learning disabilities, physical, psychological or chronic conditions you may have:_____

_____

_____

Do you require assistance with any of the above conditions? YES/NO If so, list accommodations:_____

Do you receive disability benefits? _____ Do you have health insurance? **YES/NO**

If so, please list your insurance company: _____

MENTAL HEALTH:

In the **past year or lifetime,** have you experienced a significant period of time with the following? (Not as a result of drug/alcohol use or during periods of withdrawal).

Circle all that apply:

Depression: Lifetime or Past Year

Difficulty controlling violent behavior: Lifetime or Past Year

Thoughts of suicide (Suicide ideation): Lifetime or Past Year

Difficulty understanding or concentrating: Lifetime or Past Year

Attempted suicide: Lifetime or Past Year

Hallucinations: Lifetime or Past Year

Anxiety: Lifetime or Past Year

Flashbacks of Traumatic event: Lifetime or Past Year

In the **past year**, have you been prescribed medication for a psychological or emotional problem? **YES / NO**

If so, what medication? _____Dosage: _____
Medication? _____Dosage: _____
Medication? _____Dosage: _____
Medication? _____Dosage: _____
Medication? _____Dosage: _____

Have you **ever** been diagnosed with a mental health or personality disorder? **YES / NO**
If so, what? _____

SUBSTANCE ABUSE:

Prior to acceptance into the Treatment Court Program, you are required to obtain a substance abuse evaluation. More than likely you have already been required by the court in which you are charged to have this evaluation.

Do you smoke tobacco? **YES/NO** Do you chew tobacco? **YES/NO**

How old were you when you first tried alcohol or another drug? _____
What was the drug? _____

Have you ever had an alcohol/drug evaluation? **YES/NO** When and where was it?

_____

Have you been diagnosed with chemical dependency? **YES/NO** What substance(s)?

_____

Have you ever gone to counseling or treatment for addiction? **YES / NO**
Please list treatment episodes, where it was provided, if it was out-patient or residential, and if you successfully completed the program:

_____

_____

_____

Do you have a current substance abuse problem?_____
Do you have a current alcohol abuse problem? _____
Have you ever had an issue with drugs or alcohol if not current: _____

Circle the drugs, which you have used more than 10 times:

Marijuana	Cocaine	Methamphetamine	Benzodiazepines
Hallucinogens	Heroin	Opiates	Prescription pills
Fentanyl	Kratom	Alcohol	

Other: _____

What is/are your current drug(s) of choice?

_____

Do you consume alcohol? **YES/NO** How often?

_____

Amount of substance used at one time at the time of active addiction?

_____

Drug used in the past year	Age first used	How often	Last use

Have you ever injected (intravenous use) substances? **YES / NO**
If so, when, what and how often? _____

How much do you spend a month to support your addictions? _____

FINANCES

What is the source of the money on which you have recently been living? i.e., wages, child support, disability payments, pension, food stamps, subsidized housing, living with relatives, etc. _____

Living Expenses:

Do you rent or own your home? _____ Do you pay monthly for mortgage/rent?_____
How long have you lived at this address?_____
What is the total you pay for monthly utilities? _____
Do you pay for childcare and/or child support? YES/NO. If yes, list amount: _____
Do you have credit cards? YES/NO. Approximate amount of credit card debt? _____
Do you have a vehicle payment? YES/NO. Amount of vehicle payment? _____
Approximate amount owed on the vehicle: _____
Vehicle insurance payment? _____ Insurance Company:_____

Please list any other expenses and/or debts you have:_____
_____
_____

What amount do you need to earn to cover your monthly living expenses?_____

What is your estimate of your total outstanding debt? _____

YOUR REASONS FOR PLACEMENT IN THE TREATMENT COURT:

Do you believe that you need substance abuse treatment? **YES / NO**

Do you believe that substance abuse treatment would be effective for you?

YES / NO

How did you first learn of the Treatment Court?

_____

Tell us anything more you would like us to know and consider about you and your situation. Please explain your reasons for wanting in Treatment Court. What do you think you will get out of the program?

_____

_____

_____

_____

_____

_____

_____

_____

Confidentiality:

I understand that the Treatment Court of Sweetwater County files are confidential. That I must sign releases for all information regarding my participation in the Treatment Court. I understand that I may not discuss, relay, transcribe, and/ or confer any information I may learn about any Treatment Court of Sweetwater County participant with anyone other than the Treatment Court of Sweetwater County team members. I understand that by attending the Treatment Court of Sweetwater County hearings I may not discuss to any person outside of the Treatment Court of Sweetwater County program any information identifying any participant in the Treatment Court of Sweetwater County program.

I understand that any violation of the confidentiality of drug and/or alcohol treatment records disclosure requirements is a federal crime.

I would like to apply for Treatment Court of Sweetwater County. If I am accepted, I understand that:

- I must live in an approved drug/alcohol/weapon free environment during my time in Treatment Court of Sweetwater County.
- I must have a working, charged cell phone with adequate minutes with me at all times.

- I will be subject to an enhanced supervision with restrictions that could include, but are not limited to,
    - residential confinement,
    - curfews,
    - immediate sanction(s), such as
    - electronic monitoring and/or
    - county jail time, and
    - increased contact with probation agent(s), law enforcement officers, attorneys, the courts, and treatment providers.
- Any contact with others must be approved by my probation agent prior to contact. No social media will be approved.
- I will be required to attend treatment, probation and parole visits, court hearings, and self-help meetings.
- I will be on a strict schedule and cannot deviate from that schedule unless I have permission from my probation agent.
- I will have limited time in the community, but this will increase as I work through and complete levels.
- I will be charged and must pay $60 monthly while in Treatment Court of Sweetwater County.
- I will be required to be a productive citizen through work, education, and/or community service.

_____

Signature of Applicant Date

_____

Witness Date

FOR OFFICIAL USE ONLY

County Attorneys:

Cr. History: Disqualifications: _____

_____

_____

_____

Treatment: ASAM Level: _____

_____

_____

Legal Disposition:

_____

_____

_____

Official Use Only:

Accepted/denied as Treatment Program candidate; YES_____ NO _____

Date of acceptance: _____

Reason for Denial _____

Notes:

AUTHORIZATION FOR THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

- Psychotherapy Notes or Substance Abuse Records -

This authorization fully complies with the standards set forth by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I, _____, authorize the following individual, entity or agent to make the authorized use and/or disclosure of my protected health information (PHI):

SWEETWATER COUNTY TREATMENT COURT TEAM

I authorize the aforementioned individual, entity, or agent to release and/or disclose the following information:

_____Initial here if requesting all Psychotherapy notes and/or substance abuse records. Psychotherapy Notes are notes that a mental health professional makes, in any medium, that document or analyze the contents of conversations during private, group, joint or family counseling sessions and that are separated from the rest of the individual's medical record. Includes medication, prescription, monitoring; counseling session start and stop times; treatment modalities and frequencies; clinical test results; diagnosis, functional status, treatment plan, symptoms, prognosis, or progress summary.

I authorize the Treatment Program of Sweetwater County to receive my protected health information, or any other information from the Detention Center for purposes of obtaining information, which may be required regarding my participation with The Treatment Program.

I authorize the Treatment Court Program of Sweetwater County to receive my protected health information, for purposes of obtaining information, which may be required regarding my participation with the Treatment Program.

I authorize all clinicians, case managers, physicians, dentists, medical practitioners, nurses, pharmacists, hospitals, medical examiners, affiliated with the above-listed entity to be interviewed by the Treatment Program of Sweetwater County, and/or their agent.

I understand that this consent is subject to revocation at any time except to the extent that the program which is to make the disclosure has already taken action in reliance on it. If not previously revoked, this Authorization shall remain in full force and effect for a period of two (2) years from the date set forth below, the duration of term as participant in the Treatment Court Program of Sweetwater County, or termination from the Treatment Program, whichever comes first.

A photo static copy of this Confidential Release of Records may be accepted in lieu of the original and shall be as fully binding as though it were the original executed by me.

Dated this _____ day of _____, 2025.

Signature _____

Dob: _____ **SSN#** _____

Acknowledged before me on this _____day of_____, 2025
WITNESS
Signature: _____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.

AUTHORIZATION FOR THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

- Psychotherapy Notes AND Substance Abuse Records -

This authorization fully complies with the standards set forth by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I _____, authorize the following individuals, entities or agents to make the authorized use and/or disclosure of my protected health information (PHI):

SOUTHWEST COUNSELING SERVICE

I authorize the aforementioned individuals, entities, or agents to release and/or disclose the following information:
_____Initial here if requesting a copy of the substance abuse and clinical evaluation completed at

_____ Initial here if requesting all Psychotherapy notes or substance abuse records. Psychotherapy Notes are notes that a mental health professional makes, in any medium, that document or analyze the contents of conversations during private, group, joint or family counseling sessions and that are separated from the rest of the individual's medical record. Includes medication, prescription, monitoring; counseling session start and stop times; treatment modalities and frequencies; clinical test results; diagnosis, functional status, treatment plan, symptoms, prognosis, or progress summary.

I authorize the Treatment Court Program of Sweetwater County to receive my protected health information, for purposes of obtaining information, which may be required regarding my participation with the Treatment Program.

I authorize all clinicians, case managers, physicians, dentists, medical practitioners, nurses, pharmacists, hospitals, medical examiners, affiliated with the above-listed entity to be interviewed by the Treatment Program of Sweetwater County, and/or their agent.

I understand that this consent is subject to revocation at any time except to the extent that the program which is to make the disclosure has already taken action in reliance on it. If not previously revoked, this Authorization shall remain in full force and effect for a period of two (2) years from the date set forth below, the duration of term as participant in the Treatment Court Program of Sweetwater County, or termination from the Treatment Program, whichever comes first.

A photo static copy of this Confidential Release of Records may be accepted in lieu of the original and shall be as fully binding as though it were the original executed by me.

Dated this _____ day of _____, 2025.

Signature _____

Dob: _____ SSN# _____

Acknowledged before me on this _____ day of_____, 2025
WITNESS
Signature: _____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.

AUTHORIZATION FOR THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

- Psychotherapy Notes AND Substance Abuse Records -

This authorization fully complies with the standards set forth by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I,_____, authorize the following individual, entity or agent to make the authorized use and/or disclosure of my protected health information (PHI):

PROBATION AND PAROLE, DEPARTMENT OF CORRECTIONS, SWEETWATER COUNTY, WYOMING

I authorize the aforementioned individual, entity, or agent to release and/or disclose the following information:

_____ Initial here if requesting all Psychotherapy notes or substance abuse records. Psychotherapy Notes are notes that a mental health professional makes, in any medium, that document or analyze the contents of conversations during private, group, joint or family counseling sessions and that are separated from the rest of the individual's medical record. Includes medication, prescription, monitoring; counseling session start and stop times; treatment modalities and frequencies; clinical test results; diagnosis, functional status, treatment plan, symptoms, prognosis, or progress summary.

_____All records from Probation and Parole, including a copy of the **ASI/PSI**.

I authorize the **Treatment Court Program of Sweetwater County** to receive my protected health information and probation records for purposes of obtaining information, which may be required regarding my participation with The Treatment Program.

I authorize the Treatment Court Program of Sweetwater County to receive my protected health information, for purposes of obtaining information, which may be required regarding my participation with the Treatment Program.

I authorize all clinicians, case managers, physicians, dentists, medical practitioners, nurses, pharmacists, hospitals, medical examiners, affiliated with the above-listed entity to be interviewed by the Treatment Program of Sweetwater County, and/or their agent.

I understand that this consent is subject to revocation at any time except to the extent that the program which is to make the disclosure has already taken action in reliance on it. If not previously revoked, this Authorization shall remain in full force and effect for a period of two (2) years from the date set forth below, the duration of term as participant in the Treatment Court Program of Sweetwater County, or termination from the Treatment Program, whichever comes first.

A photo static copy of this Confidential Release of Records may be accepted in lieu of the original and shall be as fully binding as though it were the original executed by me.

Dated this _____ day of _____, 2025

Signature: _____

Dob: _____ **SSN#** _____

Acknowledged before me on this _____day of_____, 2025
WITNESS
Signature: _____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.

Southwest Counseling Service

Enriching lives through wellness, recovery, and hope

AUTHORIZATION FOR RELEASE/REQUEST OF INFORMATION

☐ 2300 Foothill Blvd Rock Springs, WY 82901	☐ 1124 College Drive Rock Springs, WY 82901	☐ 2706 Ankeny Way Rock Springs, WY 82901

Name: _____
First Middle Last

Social Security Number: _____ Date of Birth: _____

I hereby authorize Southwest Counseling Service to Release/Request information from/to:

Treatment Court of Sweetwater County
50140C US Highway 191 Suite 216
Rock Springs, WY 82901

Phone: 307-922-5238
Fax: 307-872-3971

The purpose of this disclosure/request is: Compliance with Program

Please initial next to each specific record you are authorizing to be released or are requesting.
Records may be released via phone, mail, fax, or e-mail.

Release	Request	
☐ _____	☐ _____	Case Consultation
☐ _____	☐ _____	Clinical Assessment and Diagnosis
☐ _____	☐ _____	Discharge Summary
☐ _____	☐ _____	Psychiatric Assessment
☐ _____	☐ _____	Psychiatric Notes
☐ _____	☐ _____	Psychological Evaluations
☐ _____	☐ _____	Progress Notes
☐ _____	☐ _____	Progress in Treatment
☐ _____	☐ _____	Treatment Attendance
☐ _____	☐ _____	Treatment Plan
☐ _____	☐ _____	Other UA/Testing Results and ASI

Release	Request	
☐ _____	☐ _____	Billing Information
☐ _____	☐ _____	Lab Results
☐ _____	☐ _____	Medical Records
☐ _____		Medication (Pick Up)
☐ _____		Appointment Information

Request	
☐ _____	Legal
☐ _____	Attendance/Grades-School

This consent will remain in force for: ☐ one year ☐ less (to expire on the date specified) _____

_____ _____
Client Signature/Date Client's Agent or Representative Signature/Date

_____ _____
Witness Signature/Date Relationship to Client

This form must be notarized if signed and witnessed outside of an SCS Office.

Fee of .50 cents per page may be assessed for records released from SCS.
I understand that my behavioral health treatment records, including drug and alcohol records, are protected under the federal regulations governing Confidentiality and Behavioral Health Records, 42 CRF, Part 2 and 45 CFR, Parts 160 and 164, and cannot be disclosed without my written authorization, unless otherwise provided for by the regulations. A general authorization for the release of information is NOT sufficient for this purpose.

Potential for Re-disclosure: Southwest Counseling Service cannot guarantee that information released to outside sources will be protected from re-disclosure.

Revocation: Complete only if the client has chosen to revoke their prior authorization for release of private health information.

I understand that I may revoke this consent to release or request confidential information at any time verbally or by signing the revocation section of this form. Southwest Counseling Service will place this revocation in my chart. I further understand any such revocation does not apply to information which action has already been taken.

I hereby revoke this authorization _____ _____ _____:_____
Client and/or Legal Guardian Date Time Revoked