

**MONROE CIRCUIT COURT ADULT PROBATION SERVICES
COURT ALCOHOL AND DRUG SERVICES / PROBLEM-SOLVING COURT
INTAKE AND ORIENTATION FORMS**

You have been directed by the Court to report to the Monroe Circuit Court Probation Department. A substance abuse assessment will be conducted by a Probation Officer (PO) who has special training regarding substance use disorder. The participation fee for the Court Alcohol and Drug Program is **\$300** for misdemeanor convictions, **\$400** for felony convictions. Payment may be made by cash, money order, or credit/debit card; payment arrangements can be made with your assigned PO. After your initial interview, a report will be prepared to include recommendations for substance abuse education and/or treatment if indicated. All information obtained is confidential within the Court system and will not otherwise be released without your written consent.

Probation Department hours: 8:00 A.M. – 5:00 P.M. Monday – Thursday 8:00 A.M. – 4:00 P.M. Friday

ASSESSMENT AND REFERRAL PROCEDURES

1. After completion of the attached forms, a Probation Officer (PO) will review these forms with you in a private interview.
2. The PO will ask questions to gather information about your family, social history, education, employment, medical history, use of alcohol/drugs, as well as other significant areas.
3. After this interview, the PO will discuss with you possible recommendations including substance abuse education and/or treatment.

ADMISSION TO COURT ALCOHOL AND DRUG PROGRAM

Your admission to the program is decided upon solely by the judge of the Court involved. Should the judge determine that you are an appropriate candidate for admission to this program, the judge may order you to participate in any combination of the following:

- | | |
|---|---|
| 1. Alcohol / Drug Education classes | 5. Intensive Outpatient Program (IOP) |
| 2. Substance Abuse Education with further follow-up | 6. Inpatient, residential, or halfway house |
| 3. Support Groups | 7. Case Management |
| 4. Outpatient Counseling | 8. Drug Testing |

The Probation Officer will explain the goals for each service offered by the program, to include:

1. Assessment to identify specific problematic issues and determine an appropriate level of intervention to assist in preventing further substance abuse-related problems.
2. Substance abuse education to provide current and effective education for substance abuse issues for clients who, through assessment, appear to be appropriate for this level of intervention and to help prevent further substance abuse-related problems.
3. Referral to substance abuse treatment for clients, through assessment, found to be in need of treatment services. All treatment agencies utilized by the program are certified by the Indiana Division of Mental Health and Addiction to provide treatment services.
4. Effective case management of all clients to monitor a client's participation in substance abuse education or treatment programs and to ensure that clients are receiving quality services to address their specific substance abuse issues and needs.

Persons admitted to the program are typically placed on supervised probation and are required to report to their PO as directed. Length of time in the program is based upon the date of discharge from probation supervision. Probation fees are \$20 per month for misdemeanors, \$30 per month for felonies. The Court may order you to abstain from alcohol and non-prescription drugs during the term of your probation and may require you to submit to drug tests to monitor your substance use. You will be responsible for paying drug testing fees and all fees charged by the agency to which you are referred.

NOTICE OF POSSIBLE ADMINISTRATIVE SANCTIONS

ALLEGED VIOLATIONS: The Monroe Circuit Court allows a PO to utilize an administrative process to impose certain consequences/sanctions should you admit to violating conditions of your probation/community supervision and waive appearing before the Court. Sanctions may include, but are not limited to, more frequent reporting, performing community service work, or a referral to and participation in other programs or services. Any agreed-upon sanction that results in a loss of freedom, such as being placed on home detention or spending a weekend in jail, must be approved by the Court. You always maintain the right to not participate in such an administrative process and may request that any alleged violation of your probation/community supervision be addressed by the Court.

INVOLUNTARY TERMINATION PROCEDURES

An involuntary termination may result if one or more of the following should occur:

1. Additional criminal or alcohol / drug related arrests.
2. Failure or refusal to participate in and successfully complete any substance abuse education and/or treatment ordered by the Court or Probation Department. For such failure or refusal, the PO may file a memorandum or petition with the Court which could result in the client being required to serve his/her suspended jail sentence
3. Causing disruption of program activities after being requested to stop.
4. Attending any scheduled meeting or appointment under the influence of alcohol or illegal drugs.
5. Violating terms of your Order of Probation, Sentencing Order, and/or violating the terms of your community supervision. A Petition to revoke your suspended sentence may be filed with the Court to notify the judge of an alleged violation. The decision of termination rests solely with the judge. Should you be terminated from the program, you will be directed to an appropriate referral service.

CLIENT RIGHTS

Persons will not be discriminated against on the basis of race, sex, religion, gender, national origin, ethnicity, sexual orientation, age, disabilities, marital status, socioeconomic status, or political affiliation. Each client has the following rights:

1. The right to confidentiality under federal and state laws relating to the receipt of services.
2. The right to be informed of the various steps and activities involved in receiving services.
3. Right to humane care and protection from harm, abuse, and neglect.
4. Right to contact and consult with an attorney of the client's choice at the client's expense.
5. Right to make an informed decision whether to participate in the program or refuse participation and be sent back to the referring court. The client's consent to receive program services must be in writing and be included in the client's record. The specific course of education and/or treatment will be determined by the Case Manager/Probation Officer assigned to your case.

Alleged Violations of Client Rights: Clients may report possible violations of the client's rights by filing a grievance with the Court Alcohol and Drug Services Program Director or the Chief Probation Officer [phone (812) 349-2645 or email probation@co.monroe.in.us] or calling the Presiding Judge at (812) 349-2635. Pursuant to federal law (42 CFR Part 2 Section 2.22(b)), clients may report alleged violations of the regulations to the United States District Attorney for the Southern District of Indiana at the following address:

United States Attorney's Office
10 W Market St, Suite 2100
Indianapolis, IN 46204

Filed grievances may also require that the complaint be made in writing so that the alleged violation may be reviewed, a determination made, and the complaint resolved. Alleged violations will be investigated by the Chief Probation Officer (or designee) with all parties involved. The results of such investigation will be documented in the client's record and, if substantiated, in the personnel record of the staff involved. Complaints regarding the program staff or Director will not influence in any way the services provided to the client.

CONFIDENTIALITY REQUIREMENTS

Clients may request to review their case record. Clients' review of their case record, and/or denial of such review and reasons for denial, shall be recorded in the case record. Withholding from the client all or part of the client's record is permitted by policy if:

- a. withholding is necessary to protect the confidentiality of other sources of information;
- b. it is determined that the information requested may result in harm to the physical or mental health of the client or another person;
- c. the consent was not given freely, voluntarily, and without coercion; or
- d. granting the request will cause substantial harm to the relationship between the client and the program or to the program's capacity to provide services in general.

This program must comply with all federal and state laws, including federal laws and regulation pertaining to the confidentiality of alcohol and drug abuse patient records. The program is prohibited by federal law and regulations from disclosing any information that would identify a person as having or having had a substance use disorder (SUD) unless that person provides written consent. [See 42 U.S.C. 290dd-2 for federal laws and 42 CFR part 2 for federal regulations; 42 CFR part 2 prohibits unauthorized disclosure of these records.]

Generally, the program may not say to a person outside the program that a person attends the program, or disclose any information identifying a person as an alcohol or drug abuser unless: 1) The participant consents in writing; 2) The disclosure is allowed by a Court order; 3) The disclosure is made to medical personnel in a medical emergency; 4) The disclosure is made to qualified personnel for research, audit, or program evaluation; or 5) The disclosure is to authorities involved in the investigation and prosecution of a client for alleged violations, including child abuse and neglect.

RECORDING APPOINTMENTS FOR PROBATION OFFICER TRAINING/PRACTICE

Probation Officers (POs) are required to record some client appointments for training and quality assurance purposes. These recorded appointments will be viewed only by authorized probation department staff and other evaluators for the purposes of training, evaluating, and improving performance of probation staff and the probation department. Clients are not required to be recorded and clients' decision to be recorded, or not, will not be used against them in any way during the course of probation supervision. The contents of the recording will remain confidential and considered work product and will not be released to the client, attorneys, or general public.

AUTOMATED CALLS/TEXT MESSAGES

Be advised that you may receive automated calls or text message from phone number (812) 558-9115 or (812) 349-2645 that have been generated by the Probation Department to remind you of future events related to Court or probation obligations. **NOTE: You may be required to arrive at your court hearings early to watch a recording notifying you of your rights. If you are required to arrive earlier to watch a recording, you must attend at the time you were given in addition to the hearing time listed in this message.**

I hereby certify that I have read and understand the above information, and I have been provided a copy of this form.

Name (PLEASE SIGN HERE)

Date

Adult Orientation Form 20241205

ADULT CLIENT DEMOGRAPHIC FORMS

PERSON DETAIL

Name: _____
(First) (Middle) (Last)

Maiden and/or Married Names: _____

Nicknames/Alias/Other Names Used: _____

Race: Caucasian / White Black / African American Multiracial Asian
 American Indian/Alaskan Native Native Hawaiian or Other Pacific Islander Other (specify) _____

Sex: Male Female Preferred Pronouns: _____

Gender: Male Female Transgender Non-binary Other: _____

Date of Birth: _____ - _____ - _____
(Month) (Day) (Year)

Ethnicity: Hispanic/Latino Not Hispanic/ Latino

Citizenship: US Citizen (Native or naturalized) Non US Citizen

Primary Language: English Spanish Sign Language Arabic Chinese Japanese
 Korean Other Language (specify) _____

Marital Status: Married Separated Single Divorced Widowed Living together not married

Religion (optional): _____ **Height:** _____ **Weight:** _____

Hair Color: Bald Black Blonde Brown Gray Red White Other

Eye Color: Black Blue Brown Gray Green Hazel Other

Place of Birth: _____ **Social Security Number:** _____ -- _____ -- _____
(City & State)

Other States Resided In: _____

ADDRESS/CONTACT INFORMATION

Current/Home/Local Address: _____
(Number / Street) (Apt/Lot) (City/State) (Zip)

Mailing Address: _____
(if different from above) (Number / Street) (Apt/Lot) (City/State) (Zip)

Permanent Address: _____
(if different from above) (Number / Street) (Apt/Lot) (City/State) (Zip)

Contact Numbers: _____
Cell Accept text messages? yes no Home Work Phone & Extension

Email Address: _____

Emergency Contact #1 _____
(Name and Relationship) (Contact Cell & Home Numbers)
Address _____

Emergency Contact #2 _____
(Name and Relationship) (Contact Cell & Home Numbers)
Address _____

PHYSICAL IDENTIFIERS

Scars/Identifying Marks: Please check all that apply and provide location and a description of the identifier on the lines below.

- Birth Mark _____
- Body Piercing _____
- Scars _____
- Tattoos _____
- Miscellaneous Identifying Information _____

OTHER IDENTIFIERS

Driver's License Number _____ **State issued:** _____

Current Driver's License Status: Valid Suspended Expired Never Licensed Restricted

Vehicle Make/Model/Year: _____ **Vehicle Color:** _____

State ID: _____ **State issued:** _____ **Status:** Valid Expired

Resident Alien or Green Card Number: _____

Gang Affiliation: yes no If Yes, name: _____

SCHOOLS ATTENDED

Please list the name of the school(s) you attended or are currently attending:

High School: _____
(Name of High School / City and State)

Start date: _____ End date: _____ Year graduated: _____

High School Status: Attending/Currently Enrolled Completed/Graduated Dropped Out Expelled

Last High School Grade Completed: 9th 10th 11th 12th

High School Diploma TASC / GED when and where was it received? _____
Year / City / State

College/Trade School

#1: _____
(Name of School / City and State)

College or Trade School Start date: _____ End date: _____ Year graduated: _____

College/Trade School #1 Status: Attending/Enrolled Completed Graduated Dropped Out
 Pending Admission Withdrew

College/Trade School #2: _____
(Name of School / City and State)

College or Trade School Start date: _____ End date: _____ Year graduated: _____

College/Trade School #2 Status: Attending/Enrolled Completed Graduated Dropped Out
 Pending Admission Withdrew

Degree(s)/Certificate(s): Please check all that apply: Certificate Associates Degree
 Bachelor's Degree Master's Degree

EMPLOYMENT

Employment Status: Full time Part time Laid off Disabled Homemaker Unemployed
 Retired Student Self-Employed (explain): _____

Current Employer: _____ (Name / Business Name) _____ (Start Date)

(Number / Street Address)

(City) (State) (Zip) (Average Hours per week)

Position: _____ **Hourly Income or Annual Income: \$** _____

Previous Employer: _____ (Name / Business Name) _____ (Start Date)

(Number / Street Address) _____ (End Date)

(City) (State) (Zip) (Average Hours per week)

➤ **Reason for Leaving Previous Employer:** Laid off Quit Retired Terminated/Fired Disabled

MILITARY HISTORY

Yes No If YES, current or past? Current Past Branch of Service _____

Dates of service: _____ to _____ Type of discharge: _____

Do you receive VA benefits? Yes No

Did you have any injury(ies) during your deployment? Yes No

LEGAL HISTORY (JUVENILE AND/OR ADULT)

Have you ever been charged with a prior criminal offense? yes no If yes, where? _____

Have you ever been convicted of a felony? yes no If yes, where? _____

Have you ever been placed on probation? yes no If yes, where? _____

Have you ever been incarcerated in a state prison? yes no If yes, where? _____

If yes to any of the above, please list the offense(s)/charge(s), date of offense(s)/charge(s), and County/State:

Offense(s): _____

County / State: _____ Date(s): _____

Do you have **pending** legal charges against you in any other county or state? yes no

If yes, please list Charges, County/State, and Date of Charges:

Pending Charge(s): _____

County / State: _____ Date(s): _____

FAMILY INFORMATION

Number of times married: _____ Date of most recent marriage: _____ Date of most recent divorce: _____

Spouse/Significant Other: _____ Date of Birth _____ - _____ - _____
(First) (Middle) (Last) (Month) (Day) (Year)

Address: _____
(If different from yours) (Number / Street) (Apt/Lot) (City/State) (Zip Code)

Contact Numbers: Cell _____ Home _____ Work _____

Father: _____ Date of Birth _____ - _____ - _____
(First) (Middle) (Last) (Month) (Day) (Year)

Address: _____
(Number / Street) (Apt/Lot) (City/State) (Zip Code)

Contact Numbers: Cell _____ Home _____

Mother: _____ Date of Birth _____ - _____ - _____
(First) (Middle) (Last) (Month) (Day) (Year)

Address: _____
(Number / Street) (Apt/Lot) (City/State) (Zip Code)

Contact Numbers: Cell _____ Home _____

Step-Father: _____ Date of Birth _____ - _____ - _____
(First) (Middle) (Last) (Month) (Day) (Year)

Contact Numbers: Cell _____ Home _____

Step-Mother: _____ Date of Birth _____ - _____ - _____
(First) (Middle) (Last) (Month) (Day) (Year)

Contact Numbers: Cell _____ Home _____

Brothers/Sisters (including half/step):

Name _____ Date of Birth: _____ - _____ - _____
(First) (Middle) (Last) (Phone Number) (Month) (Day) (Year)

Relationship: Full Half Step **Sex:** Male Female

Name _____ Date of Birth: _____ - _____ - _____
(First) (Middle) (Last) (Phone Number) (Month) (Day) (Year)

Relationship: Full Half Step **Sex:** Male Female

Name _____ Date of Birth: _____ - _____ - _____
(First) (Middle) (Last) (Phone Number) (Month) (Day) (Year)

Relationship: Full Half Step **Sex:** Male Female

➤ **Additional paper may be used/requested from Receptionist is needed to list additional Brothers/Sisters.**

CHILDREN

Number of children? _____

Number of children you are supporting: _____

Name: _____ Date of Birth _____ - _____ - _____
(First) (Middle) (Last) (Month) (Day) (Year)

Address: _____
(Number / Street) (Apt/Lot) (City/State) (Zip) (Home Phone Number)

Relationship: Biological Step Sex: Male Female

Amount of Court-Ordered Financial Support: \$ _____ per week month Current on support? Yes No

Name: _____ Date of Birth _____ - _____ - _____
(First) (Middle) (Last) (Month) (Day) (Year)

Address: _____
(Number / Street) (Apt/Lot) (City/State) (Zip) (Home Phone Number)

Relationship: Biological Step Sex: Male Female

Amount of Court-Ordered Financial Support: \$ _____ per week month Current on support? Yes No

Name: _____ Date of Birth _____ - _____ - _____
(First) (Middle) (Last) (Month) (Day) (Year)

Address: _____
(Number / Street) (Apt/Lot) (City/State) (Zip) (Home Phone Number)

Relationship: Biological Step Sex: Male Female

Amount of Court-Ordered Financial Support: \$ _____ per week month Current on support? Yes No

Name: _____ Date of Birth _____ - _____ - _____
(First) (Middle) (Last) (Month) (Day) (Year)

Address: _____
(Number / Street) (Apt/Lot) (City/State) (Zip) (Home Phone Number)

Relationship: Biological Step Sex: Male Female

Amount of Court-Ordered Financial Support: \$ _____ per week month Current on support? Yes No

Please list all the people who are presently living with you:

(First Name) (Middle) (Last) (Relationship) Date of Birth: _____ - _____ - _____
(Month) (Day) (Year)

(First Name) (Middle) (Last) (Relationship) Date of Birth: _____ - _____ - _____
(Month) (Day) (Year)

(First Name) (Middle) (Last) (Relationship) Date of Birth: _____ - _____ - _____
(Month) (Day) (Year)

(First Name) (Middle) (Last) (Relationship) Date of Birth: _____ - _____ - _____
(Month) (Day) (Year)

FINANCIAL INFORMATION

Your Monthly Income (approximate): \$ _____

Spouse/Partner Monthly Income (approximate): \$ _____

Other (public assistance, trust fund, etc.): \$ _____

Sources of Income (**check all that apply**):

- Salary from job Social Security SSI Retirement/Pension
- WIC Vouchers Section 8 Housing Title 20 TANF
- Child Support Food Stamps Disability Other (specify) _____

Estimate the total amount of your average monthly living expenses: \$ _____

Do you believe you have ever had a problem with betting money or gambling including playing the lottery? yes no

MEDICAL, PHYSICAL, AND EMOTIONAL HEALTH

Family Doctor: _____

Are you taking any prescription or over-the-counter medications at this time? yes no

If yes, please list names of medications and reason: _____

Please list history of serious medical problems and/or any current medical problems/conditions: _____

Do you have medical insurance? yes no Insurance Provider?: _____

Have you ever had contact with or received services from a counseling, therapy or mental health agency? yes no

If yes, please list the agency(s), location, and date: _____

Agency	City & State	Date(s)
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Have you ever experienced any of the following?

- | | | | | |
|---|------------------------------|-----------------------------|---------------------------------|---|
| Allergies (severe) | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> unsure | <input type="checkbox"/> Yes / must carry EpiPen |
| Alcoholism | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> unsure | <input type="checkbox"/> Yes / in recovery |
| Anger problems / Anger outbursts | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> unsure | |
| Anxiety (severe/panic attacks) | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> unsure | |
| Asthma | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> unsure | |
| Autism | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> unsure | |
| Cancer | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> unsure | |
| Chronic Pain | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> unsure | |
| Depression (lasting more than two weeks) | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> unsure | |
| Diabetes | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> unsure | |
| Fatigue for long periods | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> unsure | |
| Feelings of hopelessness | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> unsure | |
| Financial loss due to gambling | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> unsure | |
| Seizures | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> unsure | |
| Sleep disturbance | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> unsure | |
| Substance abuse or addiction | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> unsure | <input type="checkbox"/> Yes / in recovery |
| Current suicidal thoughts | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> unsure | |
| Past suicidal thoughts | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> unsure | |
| Suicide attempts | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> unsure | |
| Temper problems | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> unsure | |
| Tendency toward violence | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> unsure | |
| Thoughts of homicide | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> unsure | |
| Weight changes (unplanned) | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> unsure | |
| Unconscious from blow to head and/or concussion | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> unsure | <input type="checkbox"/> Traumatic Brain Injury (diagnosed) |

SUBSTANCE USE INFORMATION

Have you ever used alcohol? yes no

Have you ever used illegal drugs? yes no

In the last three months, have you felt you should cut down or stop drinking or using drugs? yes no

In the last three months, has anyone told you they think you should cut down or stop drinking or using drugs? yes no

In the last three months, have you felt guilty or bad about how much you drink or use drugs? yes no

PLEASE list all prescription and nonprescription substances, including alcohol, you have used in the **past 48 hours**:

Do you believe you have a problem with alcohol and /or drugs? yes no unsure

Would you consider yourself a: recreational user substance abuser addicted or dependent

In the future, do you want to:

quit using completely

control or reduce your substance use

make no changes in regard to your substance use

Other, please explain: _____

Have you ever participated in treatment/counseling for your alcohol and/or drug use? yes no

At what facilities did you seek treatment? _____
(Name of Facility) (City & State of Facility) (Year)

Successfully completed Program? yes no

Do you believe you are in need of treatment for substance use or any other type of addictive behavior?

yes no unsure

Have you experienced any of the following from your substance use? (check all that apply)

- | | | |
|---|--|---|
| <input type="checkbox"/> Hangovers | <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Passing out | <input type="checkbox"/> Blackouts | <input type="checkbox"/> Personality changes |
| <input type="checkbox"/> Shakes / Tremors | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Delirium Tremens DTs |
| <input type="checkbox"/> Increased tolerance to alcohol | <input type="checkbox"/> Loss of control over your use | <input type="checkbox"/> Attempts at abstinence |
| <input type="checkbox"/> Preoccupation with using alcohol/drugs | <input type="checkbox"/> Overdose | <input type="checkbox"/> Hospitalization |
| <input type="checkbox"/> Family history of addiction | | |

Have you experienced problems/issues with any of the following due to your substance use? (check all that apply)

- Sleep Employment/School Relationships Financial

SUBSTANCE USE CHART	Check \checkmark if EVER used	Age First Used	Check \checkmark if currently using	Method of use (i.e., smoke, snort, inject, IV, oral/ingest etc.)	When did you last use drug?	How often (daily, weekly, monthly, etc.) are you using?
Alcohol						
Amphetamines: such as Adderall or Ritalin						
Benzodiazepines: such as (circle all that apply) Ativan Valium Xanax, Klonopin, Other Benzodiazepines _____						
Cocaine: (circle all that apply) Powder or Crack						
Heroin						
Inhalants: (circle all that apply) Glue; Paint; Nitrous Oxide; Amyl Nitrate; Other Inhalants _____						
Ketamine (Special K)						
LSD						
Marijuana/THC/Hashish						
Methamphetamine						
Nicotine						
Opiates / Opioids: (circle all that apply) Fentanyl Hydrocodone / Vicodin / Lortab Oxycodone / OxyContin Oxymorphone / Opana ER Demerol / Meperidine Darvocet Methadone Suboxone Morphine Codeine						
PCP						
Peyote/ Psilocybin Mushrooms						
Spice/K2						
Synthetics: such as Bath Salts; Ecstasy; Molly; MDMA						
Other (specify) _____						

Drug(s) of choice: _____

COMMENTS: Please write any comments you may wish to share about your current legal situation.

IDENTIFYING MEANINGFUL REWARDS

While you are on supervision, you and your probation officer will identify goals for you to accomplish. Achieving these goals will be hard work and you deserve to be recognized for what you have accomplished.

Please place a check next to any rewards listed below that you find meaningful that your probation officer can use to encourage your progress and celebrate your achievements.

- Verbal recognition
- Written recognition
- Letter of progress or completion to the Judge
- Letter of progress or completion to family members or friends
- In-person recognition by the Judge
- Certificate of completion
- Less frequent appointments
- Gift cards (please indicate type of gift card: store, restaurant, product)
- Other _____

SELF-REPORT SURVEY – COMMUNITY SUPERVISION ASSESSMENT TOOL

Name: _____

Today's Date: _____

The following questions ask about several things in your life, such as education, employment, your family, friends, and your beliefs. Please answer the following questions the best you can. There are no right or wrong answers to these questions. Some questions will be simple yes/no questions, and others will ask you to circle a number which corresponds to how much that statement reflects your beliefs or is "true" for you.

1. Highest Education

- ___ Less than 12th Grade
- ___ High School Graduate
- ___ GED
- ___ College

2. In school were you ever suspended or expelled? Yes ___ No ___

3. How long have you lived at your current address? _____

4. How many address changes have you had in the past 12 months (do not count incarceration)? _____

5. What is the age that you first began regularly using alcohol? _____

6. How long has it been since you last drank alcohol? _____

7. What is the longest period of time you have abstained from drinking? _____

8. What percent of your close friends have been in trouble with the law? _____ %

9. Would you say that you live in a "high crime" neighborhood? Yes ___ No ___

10. Were you employed at the time of your arrest? Yes ___ No ___

11. If yes, how many hours per week did you work? _____

12. Are you currently employed?

- ___ Full-time
- ___ Part-time
- ___ No, I am on disability
- ___ No, I am retired
- ___ No, not currently employed

13. In your opinion, do you have a lot of free time? Yes ___ No ___

14. On average, approximately what percent of your week is considered free time? _____ %

