INTENSIVE SUPERVISION AND TREATMENT
REFERRAL PROCESS

Probation would like to try to identify potential candidates for the IST Program as early in the process as possible.

We would like the Treatment Providers and/or Drug and Alcohol Commission's help in identifying these potential candidates.

As a rule of thumb the person is a resident of Armstrong County and is charged with at least one offense which carries a maximum penalty of five years or more (M-1) and has a drug or alcohol problem/history.

In general a DUI Tier II 3rd offense or Tier III 2nd or 3rd offense and any individual who is charged with an offense which is drug related or the offender claims is caused by drug use/abuse and is punishable by up to five years or more in prison should fill out a form.

The forms should be filled out and placed in an envelope and delivered to Kayla Pitzerell in the Probation Department. To qualify for the Intensive Supervision and Treatment (IST) Program you must be screened by the Armstrong County Probation Department.

Directions for filling out the form.

- Please fill the form out entirely. If unsure of what to put on the form please note that you were unsure.
- Please note the contact information for the Attorney handling the case. This is **very important** as we will need to send a copy of the form to the Attorney.

Should there be any questions by the defendant or Attorney, please have them contact PO Kayla Pitzerell at 724-548-3491.

Thank you,

Kayla Pitzerell
Adult Probation Officer

ARMSTRONG COUNTY INTENSIVE SUPERVISION AND TREATMENT COURT

*Referral and Application**

Complete and submit this application along with a copy of the criminal complaint and affidavit (if available) by mail or fax to: Armstrong County Probation Office, Attn: Kayla Pitzerell, 500 East Market Street, Room 303 – Courthouse, Kittanning, PA 16201; FAX (724) 548-3460; email: kmpitzerell@co.armstrong.pa.us

REFERRAL SOURCE	
Name:	Position/Title:
Phone: ( )	Email:
Relationship to Applicant:	Date of Referral:

DEFENDANT INFORMATION			
Name: *First Middle Last*			Alias: *(or maiden name)*
Physical Address: *Street*	*City*	*State*	*Zip Code*
Mailing Address: *Same as above* ☐ *Street/PO Box*	*City*	*State*	*Zip Code*
County of Residence:	Currently Incarcerated: ☐Yes ☐No		
Home Phone: ( )	Cell: ( )	Email:	
Work Phone: ( )	Primary language spoken: ☐English ☐Spanish ☐Other:		
Date of Birth:	Social Security Number:		
Race: ☐Asian/Pacific Islander ☐Bi-racial ☐Black ☐White ☐Native ☐Unknown/Unreported			
Ethnicity: ☐Hispanic ☐Non-Hispanic ☐Unknown/Unreported	Gender: ☐Male ☐Female ☐Other		
Height:	Weight:	Hair Color:	Do you have reliable transportation? ☐Yes ☐No
Possess a driver's license? ☐Yes ☐No	Status: ☐Valid ☐Suspended ☐Expired	License #:	
If revoked/suspended, are you ready to regain driver's license? ☐Yes ☐No			
Prior participation in a problem-solving court? ☐Yes ☐No	If yes, specify county:		

LEGAL REPRESENTATION			
Select One: ☐Public Defender ☐Private Attorney ☐Public Defender Pending			
Attorney's Name:	Firm *(if private)*:		
Address: *Street*	*City*	*State*	*Zip Code*
Phone: ( )	*Fax:* ( )	Email:	

CRIMINAL/CHARGE INFORMATION			
Please list all pending cases. Cases not included below will not be considered for acceptance. The addition of cases at a later date will delay the application process. You may attach an additional page if necessary.			
Docket Number	*Offense Tracking Number (OTN)*	*Offense(s)*	*Grade*

Did you use or possess a weapon? ☐Yes ☐No	If yes, list:
Have you ever had a PFA entered against you? ☐Yes ☐No	Has it been violated? ☐Yes ☐No
Attach an additional page if you have more cases and/or charges. Additional page attached? ☐Yes ☐No	

SUBSTANCE ABUSE HISTORY			
Have you ever abused drugs or alcohol? ☐Yes ☐No		Currently abusing? ☐Yes ☐No	
Have you ever received drug or alcohol inpatient or outpatient treatment? ☐Yes ☐No			Currently in treatment? ☐Yes ☐No
Drug(s) of Choice:	*1st drug of choice*	*2nd*	*3rd*
Age began using drugs:	Age began alcohol use:	History of IV Drug Use? ☐Yes ☐No	

MEDICAL/TREATMENT HISTORY	
Prior psychiatric mental health inpatient/outpatient treatment? ☐Yes ☐No	Currently in mental health treatment? ☐Yes ☐No
If yes to the questions above, was the mental health diagnosis connected to military service? ☐Yes ☐No	
Pharmacological interventions (medications) for substance abuse? ☐Yes ☐No	If yes, list medication(s): *(e.g., Methadone, Vivitrol, Suboxone)*
Medical Insurance: ☐Medicaid ☐Medicare ☐None	☐Private Insurance (specify): ☐ Other (specify):
If female, are you pregnant? ☐Yes ☐No	If yes, indicate your due date:
List any past or present medical conditions:	
List any medications you are taking:	

EDUCATION, EMPLOYMENT, AND HOUSING STATUS

Highest level of Education completed (select one):

☐Any grade up to 11th ☐GED ☐High School Diploma ☐Some Trade School
☐Trade School Graduate ☐Some College ☐College Graduate (2 year) ☐College Graduate (4 year)
☐Some Post Graduate ☐Advanced Degree

Employment Status (select one):

☐Unemployed ☐Employed Full-Time (35 or more hours/week)* ☐Volunteer
☐Retired ☐Employed Part-Time (less than 35 hours/week)* ☐Disabled
☐Student Full-Time **Specify occupation:*

Primary Source of Support (select all that apply):

☐Adoption Subsidy ☐Social Security (SSI) ☐Social Security Disability (SSD) ☐Welfare ☐None
☐Foster Care Subsidy ☐Retirement Plan ☐Workers Compensation ☐Family ☐Other
☐Unemployment ☐Veterans Benefits ☐Salary/Wages ☐Disability

Housing Status (select one): ☐Independent ☐Dependent (*incarcerated, with friends, etc*.) ☐Homeless

FAMILY/CHILDREN INFORMATION

Living Arrangements: ☐Single ☐Married* ☐Separated ☐Divorced ☐Widowed ☐Living Together*	*Name of spouse or partner:
# of Children:	# of Dependent Children:
Custody of all minor children: ☐Yes ☐No ☐N/A	
Visitation rights for all children not residing with you? ☐Yes ☐No ☐N/A	Child support amount: (if applicable)
Currently have contact with your primary family? ☐Yes ☐No ☐N/A	$ per month

ANY OTHER INFORMATION

DO NOT COMPLETE THIS SECTION - OFFICIAL COORDINATOR USE ONLY

Date(s) Distributed for Review

PSI Officer:	Attorney:	Sentencing Judge:

I,

_____ (Print Name)
, verify that the facts set forth on the foregoing application are true and correct.

Date: ____/____/_20___

_____ (Signature)

Family Counseling Center of Armstrong County

Law Enforcement Liaison

300 SOUTH JEFFERSON STREET ● KITTANNING, PA 16201-2420 ● 724/543-2941 (VOICE) ● 724/548-8119 (FAX)

Authorization for Release of Client Information BSU# _____

I, _____ , give my permission for this facility to obtain or release the following specific information on myself or my child under the age of 14:

Diagnosis, Assessments,Treatment DOB _____
Evaluations
To communicate treatment recommendations and
Discuss programming need

- ○ Please send records
- ○ Please keep on file for ongoing communication

To or from the following:

_____
_____
_____
_____

I understand that this information is being requested for the following purposes:_____
Coordinate programs, provide supports and services as recommended and requested.

I have been told that to protect the limited confidentiality of records, my agreement to obtain or release information is necessary and that this permission is limited for the purposes and to the persons listed above, and will be effective during the dates below. Upon my written request, I will be told the name, to whom, and the dates when the information will be sent, and that I may withdraw my permission at any time. This right and my other rights are contained within the Notice of Privacy Practices. I acknowledge and understand that treatment is not conditioned upon my signing of this authorization. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by this subpart. I understand that I may request in writing to see information that is sent. I also understand that the information to be released will include HIV-related information, mental health-related information, and drug and alcohol related information if contained in these records. I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization.

This consent shall be in effect from _____ until _____

_____ _____
Signature of client or parent of child under 14 years of age *Date*

_____ _____
Staff signature and degree *Date*

Client is physically unable to provide a signature, but understands the nature of the release and freely gives verbal consent: _____

_____ _____
Witnessed by *Date*

_____
Witnessed by

Copy Accepted ○ Copy Refused ○