THE STATE OF NEVADA
EIGHTH JUDICAL DISTRICT COURT
SPECIALTY COURTS
APPLICATION
Submit by e-mail to: specialtycourts@clarkcountycourts.us

Applicant Name:	
Date:	Referring Attorney:
Case number:	Attorney Phone number:
Program Requested:	

Application Instructions

1. Applications will only be accepted by e-mail.
2. It is the attorney's responsibility to:
   a. Assist their client in filling out the application in a complete manner.
   b. Gather the required records to accompany the application.
   c. Scan and e-mail the completed application, divided in three parts: part A, part B, and accompany records and reports.
3. The application and records must be scanned and e-mailed to specialtycourts@clarkcountycourts.us
4. If the application is not complete, the coordinator will "reject" the application. A complete application must be submitted in order to review for acceptance.
5. Upon notification of acceptance into the program, the attorney may place the matter on calendar in the originating court on a date prior to the previously set date for status check on acceptance.

Applicant Consent

I am applying to participate in a Specialty Court program. I authorize an employee of the Eighth Judicial District Court Specialty Court to speak with, request and obtain information from me and/or my attorney about my application for a Specialty Court program. I also consent for a Specialty Court employee to contact people listed in this application to verify residence, employment and other information regarding my application. I agree to sign all necessary releases to provide information in support of my application, including medical or mental health records. I understand that a background check will be completed. Also, if I am transferring from a specialty court program in another jurisdiction in the State of Nevada, I consent for the originating court to provide all information relating to my treatment and progress in that program. I understand that all information provided and gathered will be considered in the decision whether I am accepted into a Specialty Court program. I also understand that the information in this application will be shared with the members of the Specialty Court team; including probation, the prosecuting attorney, and any treatment provider I may work with (part A) The information in the Risk/Needs Assessment, DAST, MAST, Mental Health Screening form and supplemental questions will not be shared with the Specialty Court team (part B). This information is confidential and will be scored and reviewed by the Specialty Court Coordinator. This consent takes effect immediately and expires upon denial of my application, termination from the program or completion of the program. I understand providing false information in this application is grounds for disqualification or termination from the Specialty Court program.

Applicant Signature _____ Date _____

Any referral to a Specialty Court program must include:

- ☐ Completed Application
- ☐ Signed Participant Agreement
- ☐ Police report for current charges and any prior charges of violence, sex offense or drug sales
- ☐ PSI, if available, from this or another case
- ☐ Records documenting a history of mental illness (mandatory for Mental Health Court)
- ☐ Probation violation reports
- ☐ Any other records you feel would be helpful to determine eligibility

Failure to submit a complete application and agreement or to provide requested information will result in delay or denial of application.

Applicant Information
Part A

Program participants must reside in Clark County during the program. Under limited circumstances cases may be transferred to other parts of Nevada. Interstate compact is not available for Specialty Court participants.

Name:	Aliases:

What is your primary language? ☐ English ☐ Spanish ☐ Other: _____

Do you need an interpreter for court? ☐ Yes ☐ No

Do you need an interpreter for treatment sessions? ☐ Yes ☐ No

Address:		
City:	State:	Zip Code:
E-mail:		
Cell:	Home Phone:	
List all residents and ages:		
How long have you lived at this address?		
Who pays the rent or house payment?		
How many times have you moved in the past three years?		

Are you currently homeless? ☐ Yes ☐ No

Have you been homeless in the last three years? ☐ Yes ☐ No

Are you currently receiving housing assistance of any type? ☐ Yes ☐ No

Have you ever received housing assistance or a rent voucher? ☐ Yes ☐ No

Do you reside with anyone who uses alcohol or drugs? ☐ Yes ☐ No

Are there any weapons in your home? ☐ Yes ☐ No

Gender:	Race/Ethnicity:		Marital Status:
Height:	Weight:	Eye Color:	Hair Color:
Age:	Birth Date:	Birth Place:	
Social Security number:		Jail ID number:	

Do you have a Social Security card? ☐ Yes ☐ No

Do you have a copy of your birth certificate? ☐ Yes ☐ No

Do you have a state issued identification card or passport? ☐ Yes ☐ No

Do you have a driver's license? ☐ Yes ☐ No

Driver's License ID number:	State Issuing License/ID:
Status of Driver's License:	
Emergency Contact:	
Emergency Contact Address:	
Emergency Contact Phone:	

Legal History

Applicants may not have out-of-state extraditable warrants, immigration detainers or other holds. Applicants serving a jail or prison sentence expiring more than sixty days after referral to the program will not be accepted.

Current Charges:

Do you plead guilty? ☐ Yes ☐ No

Does your plea allow a deferral or reduction? ☐ Yes ☐ No

Have you been sentenced? ☐ Yes ☐ No

Are you in custody? ☐ Yes ☐ No

What facility?
What is your release date?
Where were you living before you were arrested?

Are you on probation or parole in this or any case? ☐ Yes ☐ No

Officer:	Officer's Phone number:

Do you have any other cases pending? ☐ Yes ☐ No

What are the charges and case numbers?
When is your next court date?

Do you have previous charges or convictions? ☐ Yes ☐ No

Please list priors:	
How many felonies?	How many misdemeanors?

Have you been convicted of arson, a sex offense or a violent crime? ☐ Yes ☐ No

Please explain:

Have you participated in any specialty court program before? ☐ Yes ☐ No

When?	What program?
What was the outcome?	

Substance Use/Gambling History

Do you think you have a substance abuse problem? ☐ Yes ☐ No

Have you ever been in treatment for a substance abuse problem? ☐ Yes ☐ No

Treatment Program	Dates Attended	Residential	Outcome
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	

Which substances have you used? Please check all that apply.

☐ Alcohol	☐ Amphetamine	☐ Barbiturates	☐ Bath Salts
☐ Benzodiazepines	☐ Caffeine/Energy Drinks	☐ Cannabis/Marijuana	☐ Cocaine
☐ Ecstasy	☐ Herbal Supplements	☐ Heroin	☐ Inhalants
☐ LSD	☐ Methadone	☐ Methamphetamine	☐ Mushrooms
☐ Nicotine/Tobacco	☐ Opiates (pain pills)	☐ PCP	☐ Spice
☐ Other:			

Identify #1 substance used:	
Main method of use:	Frequency of use:
Age at first use:	Date last used:

Was the substance prescribed to you? ☐ Yes ☐ No

Did you ever use this substance intravenously? ☐ Yes ☐ No

Identify #2 substance used:	
Method of use:	Frequency of use:
Age at first use:	Date last used:

Was the substance prescribed to you? ☐ Yes ☐ No

Did you ever use this substance intravenously? ☐ Yes ☐ No

Identify #3 substance used:	
Method of use:	Frequency of use:
Age at first use:	Date last used:

Was the substance prescribed to you? ☐ Yes ☐ No

Did you ever use this substance intravenously? ☐ Yes ☐ No

Do you gamble? ☐ Yes ☐ No

How often do you gamble?
How much do you normally spend monthly gambling?

Have you ever lied about how much you gamble? ☐ Yes ☐ No

Have you ever had financial problems because of gambling? ☐ Yes ☐ No

Has gambling impacted your living expenses? ☐ Yes ☐ No

Medical/Mental Health History

Do you have any medical conditions? ☐ Yes ☐ No

Please explain:

Do you have a mental health diagnosis? ☐ Yes ☐ No

Please explain:

Do you see any medical or mental health providers for any condition? ☐ Yes ☐ No

Names and phone numbers of doctors:

Are you currently taking any prescription medications? ☐ Yes ☐ No

What medications are you taking?
What medications have you taken in the past?

If you are female, are you currently pregnant? ☐ Yes ☐ No

Have you received prenatal care? ☐ Yes ☐ No

Where?
What is your due date?

Do you have private medical insurance? ☐ Yes ☐ No

Insurance Company?	Policy number:
Name of Policyholder:	Relationship:

Do you have Medicaid? ☐ Yes ☐ No

If yes, which program? ☐ MCO (Amerigroup) ☐ MCO (HPN) ☐ Free for Service (FFS)

Do you have Medicare? ☐ Yes ☐ No

Do you receive SSI or SSID? ☐ Yes ☐ No

Do you have any medical insurance or disability application pending? ☐ Yes ☐ No

Education and Employment History

Do you have high school diploma, GED, or HiSET? ☐ Yes ☐ No

Were you ever diagnosed with a learning disability? ☐ Yes ☐ No

Were you ever in special education or resource classes in school? ☐ Yes ☐ No

School Type	School Attended	When	Last Grade	Diploma	Area of Study
GED/HiSET					
High School					
Trade School					
College					
Post-Graduate					

List your most recent job first:

Employer	Job Title	Dates	Hours	Reason for Leaving

Are you currently eligible for unemployment? ☐ Yes ☐ No

Do you have any disability that prevents you from working? ☐ Yes ☐ No

What is your main source of financial support?
What is your total monthly income from all sources?

Military Service

Please complete this section if you have ever served in the military, even for one day.

Branch of Service:	Occupational Specialty:
Date of Entry:	Date of Discharge:
Awards:	
Discharge Status:	Rank at Discharge:

If your discharge was other than honorable, please explain:

Do you have a copy of your DD 214? ☐ Yes ☐ No

Did you serve in a combat zone? ☐ Yes ☐ No

List combat zone areas and dates:

While in the military, did you suffer any trauma? ☐ Yes ☐ No

Please check all that apply: ☐ Physical ☐ Sexual ☐ Emotional

Are you currently receiving VA benefits? ☐ Yes ☐ No

Have you enrolled with the local VA? ☐ Yes ☐ No

Have you ever applied for a service connected disability? ☐ Yes ☐ No

Miscellaneous

Do you or anyone in your household own a vehicle? ☐ Yes ☐ No

Vehicle #1 Make:	Model:	Year:
Registered Owner:		
Vehicle #2 Make:	Model:	Year:
Registered Owner:		
Vehicle #3 Make:	Model:	Year:
Registered Owner:		

Is transportation an issue for you? ☐ Yes ☐ No

If yes, please explain:

If you have children under the age of 18, please provide the following information for each child:

Child's Name	Age	Lives With	Custody Status	Child Support Organization

Do you have an open CPS or DFS case? ☐ Yes ☐ No

Caseworker's Name:	Caseworker's number:

Please provide any other information you think is important, including your top three goals for the next year.

Specialty Courts Confidentiality Statement

Records of the identity, diagnosis, prognosis, or treatment of any participant which are maintained in connection with the Eighth Judicial District Court Specialty Courts Program, or any activity relating to the application or participation in said Program including, but not limited to, the Risk/Needs Assessment, Drug Abuse Screening Test, Michigan Alcoholism Screening Test, and Mental Health Screening Form, shall be confidential in a manner consistent with Nevada Revised Statutes 49.207 through 49.213 inclusive and 42 U.S.C. § 290dd-2.

Supplemental Questions
Part B

1. List all media accounts

2. Were you arrested as a juvenile? ☐ Yes ☐ No

Please explain:

How old were you when you committed your first crime?

3. What substances have you used while pregnant?

4. Are you current on child support payments? ☐ Yes ☐ No

RISK/NEEDS ASSESMENT

1.	Have you been arrested more than three times?	☐ Yes	☐ No
2.	Did you commit your first crime before age 16, even if you weren't caught?	☐ Yes	☐ No
3.	Have you been convicted of a felony before this case?	☐ Yes	☐ No
4.	Have you ever been on probation?	☐ Yes	☐ No
5.	Are you younger than 25?	☐ Yes	☐ No
6.	Have you been convicted of a violent crime like battery, assault or robbery?	☐ Yes	☐ No
7.	Have you been convicted of domestic violence or DUI?	☐ Yes	☐ No
8.	Have you ever been involved with a gang?	☐ Yes	☐ No
9.	Do you have friends who have been to jail or prison?	☐ Yes	☐ No
10.	Do you have family members who have been convicted of a crime?	☐ Yes	☐ No
11.	Did you start using drugs or drinking alcohol before age 14?	☐ Yes	☐ No
12.	Is it hard for you to stop using or drinking once you start?	☐ Yes	☐ No
13.	Have you ever been in a drug or alcohol treatment program?	☐ Yes	☐ No
14.	Are you currently attending recovery support groups like AA, GA or NA?	☐ Yes	☐ No
15.	Do you have friends or family who help you?	☐ Yes	☐ No
16.	Do you have friends who use drugs or alcohol?	☐ Yes	☐ No
17.	Do you have family members who use drugs or alcohol?	☐ Yes	☐ No
18.	Do you generally trust other people?	☐ Yes	☐ No
19.	Do you have a stable place to live?	☐ Yes	☐ No
20.	Have you ever been out of work for more than one year?	☐ Yes	☐ No
21.	Are you currently out of work?	☐ Yes	☐ No
22.	Are you having financial problems?	☐ Yes	☐ No
23.	Do you prefer to be alone?	☐ Yes	☐ No
24.	Do you have a hard time staying focused?	☐ Yes	☐ No
25.	Are you able to ask for help when you need it?	☐ Yes	☐ No
26.	Do you normally lose your temper easily?	☐ Yes	☐ No
27.	Do you usually feel nervous or anxious around people?	☐ Yes	☐ No
28.	Do you have any serious ongoing medical conditions?	☐ Yes	☐ No
29.	Do you have any mental health issues?	☐ Yes	☐ No
30.	Do you feel sick when you stop using drugs or alcohol?	☐ Yes	☐ No

DAST (DRUG ABUSE SCREENING TEST)

1.	Have you ever used drugs other than those required for medical reasons?	☐ Yes	☐ No
2.	Have you abused prescription drugs?	☐ Yes	☐ No
3.	Do you abuse more than one drug at a time?	☐ Yes	☐ No
4.	Can you get through the week without using drugs other than those required for medical reasons?	☐ Yes	☐ No
5.	Are you always able to stop using drugs when you want to?	☐ Yes	☐ No
6.	Do you abuse drugs on a continuous basis?	☐ Yes	☐ No
7.	Do you try to limit your drug use to certain situations?	☐ Yes	☐ No
8.	Have you had blackouts or flashbacks as a result of drug use?	☐ Yes	☐ No
9.	Do you ever feel bad about your drug abuse?	☐ Yes	☐ No
10.	Does your spouse (or parents) ever complain about your involvement with drugs?	☐ Yes	☐ No
11.	Do your friends or relatives know or suspect you abuse drugs?	☐ Yes	☐ No
12.	Has drug abuse ever created problems between you and your spouse?	☐ Yes	☐ No
13.	Has any family member ever sought help for problems related to your drug use?	☐ Yes	☐ No
14.	Have you ever lost friends because of your use of drugs?	☐ Yes	☐ No
15.	Have you ever neglected your family or missed work because of your drug use?	☐ Yes	☐ No
16.	Have you ever been in trouble at work because of drug abuse?	☐ Yes	☐ No
17.	Have you ever lost a job because of drug abuse?	☐ Yes	☐ No
18.	Have you gotten into fights while under the influence of drugs?	☐ Yes	☐ No
19.	Have you ever been arrested because of unusual behavior while under the influence of drugs?	☐ Yes	☐ No
20.	Have you been arrested for driving while under the influence of drugs?	☐ Yes	☐ No
21.	Have you engaged in illegal activities to obtain drugs?	☐ Yes	☐ No
22.	Have you ever been arrested for possession of illegal drugs?	☐ Yes	☐ No
23.	Have you ever experienced withdrawal symptoms as a result of heavy drug intake?	☐ Yes	☐ No
24.	Have you had medical problems as a result of your drug use such as memory loss, hepatitis, convulsions or bleeding?	☐ Yes	☐ No
25.	Have you ever gone to anyone for help for a drug problem?	☐ Yes	☐ No
26.	Have you ever been hospitalized for medical problems related to your drug use?	☐ Yes	☐ No
27.	Have you ever been involved in a treatment program specifically related to drug use?	☐ Yes	☐ No
28.	Have you ever been treated as an outpatient for problems related to drug abuse?	☐ Yes	☐ No

MAST (Michigan Alcoholism Screening Test)

1.	Do you feel you are a normal drinker? (By normal, we mean do you drink less than or as much as most other people.)	☐ Yes	☐ No
2.	Have you ever awakened the morning after drinking the night before and found that you could not remember a part of the evening?	☐ Yes	☐ No
3.	Does your wife, husband, parent or any near relative ever worry or complain about your drinking?	☐ Yes	☐ No
4.	Can you stop drinking without difficulty after one or two drinks?	☐ Yes	☐ No
5.	Do you ever feel guilty about your drinking?	☐ Yes	☐ No
6.	Have you ever attended a meeting of Alcoholics Anonymous (AA)?	☐ Yes	☐ No
7.	Have you ever gotten into a physical fight when drinking?	☐ Yes	☐ No
8.	Has drinking ever created problems between you and a near relative or close friend?	☐ Yes	☐ No
9.	Has any family member or close friend gone to anyone for help about your drinking?	☐ Yes	☐ No
10.	Have you ever lost a friend because of your drinking?	☐ Yes	☐ No
11.	Have you ever gotten into trouble at work because of drinking?	☐ Yes	☐ No
12.	Have you ever lost a job because of drinking?	☐ Yes	☐ No
13.	Have you ever neglected your obligations, your family or your work for two or more days in a row because of your drinking?	☐ Yes	☐ No
14.	Do you drink before noon fairly often?	☐ Yes	☐ No
15.	Have you ever been told you have liver trouble such as alcoholic cirrhosis?	☐ Yes	☐ No
16.	Have you ever gone to anyone for help about your drinking?	☐ Yes	☐ No
17.	Have you ever been hospitalized because of your drinking?	☐ Yes	☐ No
18.	Has your drinking ever resulted in you being hospitalized in a psychiatric ward?	☐ Yes	☐ No
19.	Have you ever gone to a doctor, social worker, clergy person or mental health clinic for help with any emotional problem in which drinking was part of the problem?	☐ Yes	☐ No
20.	Have you been arrested more than once for driving under the influence of alcohol?	☐ Yes	☐ No
21.	Have you ever been arrested, even for a few hours, because of other behavior while drinking?	☐ Yes	☐ No

Mental Health Screening Form

1.	Have you ever talked to a psychiatrist, psychologist, therapist, social worker or counselor about an emotional problem?	☐ Yes	☐ No
2.	Have you ever felt you needed help with your emotional problems or have you had people tell you that you should get help?	☐ Yes	☐ No
3.	Have you ever been advised to take medication for anxiety, depression, hearing voices or for any other emotional problem?	☐ Yes	☐ No
4.	Have you ever been seen in a psychiatric emergency room or been hospitalized for psychiatric reasons?	☐ Yes	☐ No
5.	Have you ever heard voices no one else could hear or seen objects that others could not see?	☐ Yes	☐ No
6.	Have you ever been depressed for weeks at a time, lost interest in most activities, had trouble concentrating and making decisions or thought about killing yourself?	☐ Yes	☐ No
7.	Have you ever attempted to kill yourself?	☐ Yes	☐ No
8.	Have you ever had nightmares or flashbacks as a result of being involved in a traumatic or terrible event?	☐ Yes	☐ No
9.	Have you ever experienced any strong fears, for example, heights, insects, animals, dirt, attending social events, etc.?	☐ Yes	☐ No
10.	Have you ever given in to an aggressive urge or impulse, on more than one occasion, which resulted in serious harm to others or led to the destruction of property?	☐ Yes	☐ No
11.	Have you ever felt that people had something against you, without them necessarily saying so, or that someone or some group may be trying to influence your thoughts or behaviors?	☐ Yes	☐ No
12.	Have you ever experienced any emotional problems associated with your sexual interests, your sexual activities or your choice of sexual partner?	☐ Yes	☐ No
13.	Was there ever a period in your life when you spent a lot of time thinking and worrying about gaining weight, becoming fat or controlling your eating?	☐ Yes	☐ No
14.	Have you ever had a period of time when you were full of energy, your ideas came very rapidly, you talked nearly non-stop, you moved quickly from one activity to another, you needed little sleep and you believed you could almost do anything?	☐ Yes	☐ No
15.	Have you ever had spells or attacks when you suddenly felt anxious, frightened and uneasy to the extent that you began sweating, your heart began to beat rapidly, you were shaking or trembling, your stomach was upset or you felt dizzy or unsteady?	☐ Yes	☐ No
16.	Have you ever had a persistent, lasting thought or impulse to do something over and over that caused you considerable distress and interfered with normal routines, work or your social relations?	☐ Yes	☐ No
17.	Have you ever lost considerable sums of money through gambling or had problems at work, in school or with your family and friends as a result of gambling?	☐ Yes	☐ No
18.	Have you ever been told by teachers, guidance counselors or others that you have a special learning problem?	☐ Yes	☒ No