



**STATE OF OHIO
DEPARTMENT OF REHABILITATION AND CORRECTION
OHIO PAROLE BOARD**

**INSTRUCTIONS FOR COMPLETING
THIS QUESTIONNAIRE**

TO: Persons Requesting Clemency

This questionnaire and the clemency application are the first steps in the clemency investigation process. Your completion of this documentation honestly, completely, and legibly will benefit you and assist in making a fair decision about your clemency application. The information you provide will be verified to determine its truthfulness and accuracy. An investigator will review your application materials with you and ask further questions. At that time, you may explain or clarify your answers. Please remember to sign and date the last page of the questionnaire. Please make sure that you list all of the cases you wish to be considered for clemency on your application. Failure to do so may result in a delay in the process.

Below is a list of documents which you should provide to assist the investigator in verifying your background. Usually you can only provide these if you are not incarcerated.

| | |
|--|--|
| <p>Birth/Immigration or Naturalization papers School diplomas Proof of residence (rent receipts, property and mortgage papers, etc.) Military Records or DD214 Social Security Card Drivers License / State ID</p> | <p>Employment verification: pay stubs, tax reports, W-2's or other verification Government Assistance/Benefits List of Current Medications Prescribed Department of Job and Family Services records Other: _____ _____</p> |
|--|--|

Please provide the most accurate contact information available for you so that we may contact you to begin this investigation by listing your home phone, cell phone, and/or email address. It is extremely important that the investigator has your contact information during this investigation. The investigator will then contact you to set up an interview, either in person or via telephone.

PLEASE PRINT

| | | | |
|-------------|------|-------|--------|
| Court Name: | Last | First | Middle |
| True Name: | Last | First | Middle |

Also Known As (Include Maiden Name):

| | | |
|--------------|---------------------------------------|----------------------------------|
| Inmate ID #: | Who is your Defense Counsel/Attorney: | Def. Counsel/Attorney's Phone #: |
|--------------|---------------------------------------|----------------------------------|

| | |
|---|---------------------------|
| Your Home Address (address, city, state, zip code): | Your County of Residence: |
|---|---------------------------|

| | |
|--|---|
| Phone (where you can most easily be reached): () | What type of phone does the number provided ring to: <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell/Mobile <input type="checkbox"/> Other: _____ |
|--|---|

If the phone # you provided belongs to someone else, what is his/her name & relationship to you:

| | | | | |
|------|--|------|--------------------|--|
| DOB: | <input checked="" type="checkbox"/> <input type="checkbox"/> | Age: | Social Security #: | <input checked="" type="checkbox"/> <input type="checkbox"/> |
|------|--|------|--------------------|--|

| | | | | |
|---|---------|---------|-------|-------|
| Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female | Height: | Weight: | Eyes: | Hair: |
|---|---------|---------|-------|-------|

| | | | | |
|-------------------|--------------------------------|---|---|---|
| Race: (check one) | <input type="checkbox"/> White | <input type="checkbox"/> Black/African American | <input type="checkbox"/> Bi-Racial (Black/White) | <input type="checkbox"/> Bi/Multi Racial (Other than Black/White) |
| | <input type="checkbox"/> Asian | <input type="checkbox"/> American Indian/Alaskan Native | <input type="checkbox"/> Native Hawaiian/Pacific Islander | <input type="checkbox"/> Other: |

Are you Hispanic/Latino/Spanish: Yes No

Birthmarks/Tattoos/Major Scars/Piercings: (Describe marks/tattoos/scars/piercings and identify location on body)

List any Handicaps that may limit your abilities:

| | | |
|---|--|-------------------------------------|
| Do you speak English: <input type="checkbox"/> No <input type="checkbox"/> Yes, but only a little <input type="checkbox"/> Yes | Language Spoken (if other than english): | Interpreter (name, agency phone #): |
|---|--|-------------------------------------|

| | |
|--|---|
| Highest Grade/Degree Completed: <input checked="" type="checkbox"/> <input type="checkbox"/> | Where were you born: City: State/County: <input checked="" type="checkbox"/> <input type="checkbox"/> |
|--|---|

| | |
|---|--|
| Are you a U.S. Citizen: <input type="checkbox"/> Yes <input type="checkbox"/> No | If you are not a U.S. Citizen, what country are you a citizen of: <input checked="" type="checkbox"/> <input type="checkbox"/> |
|---|--|

If you have dual citizenship, please list second country of citizenship here:

| | |
|---|------------------------|
| What type of ID do you have: <input type="checkbox"/> Driver's License <input type="checkbox"/> State ID Card <input checked="" type="checkbox"/> None <input type="checkbox"/> | What is the ID Number: |
|---|------------------------|

| | |
|--|---|
| What state issued you your driver's license: | What is the status of your driver's license: <input type="checkbox"/> Valid <input type="checkbox"/> Expired <input type="checkbox"/> Not Applicable <input checked="" type="checkbox"/> <input type="checkbox"/> Suspended <input type="checkbox"/> Failure to Reinstate <input type="checkbox"/> Other: _____ <input type="checkbox"/> |
|--|---|

| | | | |
|--|---|--|--|
| Are you currently under any type of supervision: | <input type="checkbox"/> Yes, if yes, specify type of supervision: <input type="checkbox"/> No | <input type="checkbox"/> Pretrial Supervision <input type="checkbox"/> Parole/PRC | <input type="checkbox"/> Probation Community Control |
| Supervising Officer's Name: | Location/Court: | Supervising Office's Phone #: | |
| Do you have any outstanding charges pending and/or protection orders against you, If yes, where? | | | |

Social History

Marital

| | | | | | |
|---|---------------------------------|----------------------------------|-----------------------------------|------------------------------------|----------------------------------|
| Marital status at the time the offense was committed: | <input type="checkbox"/> Single | <input type="checkbox"/> Married | <input type="checkbox"/> Divorced | <input type="checkbox"/> Separated | <input type="checkbox"/> Widowed |
| Current Marital status: | <input type="checkbox"/> Single | <input type="checkbox"/> Married | <input type="checkbox"/> Divorced | <input type="checkbox"/> Separated | <input type="checkbox"/> Widowed |

Current Spouse/Domestic Partner:

| | | |
|---|------|-------------|
| Name: <i>(last, first, middle)</i> | Age: | Occupation: |
| Address: <i>(street, city, state, zip code and county)</i> | | |
| Has your current spouse/domestic partner ever been convicted of any crimes: <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

Previous Spouse(s)/Domestic Partner(s):

| | | |
|--|-------------------|-------------------------------------|
| Name: <i>(last, first, middle)</i> | Date of Marriage: | Date of Divorce/Separation/Widowed: |
| Address: <i>(street, city, state, zip code and county)</i> | | |
| Has this previous spouse/domestic partner ever been convicted of any crimes: <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

| | | |
|--|-------------------|-------------------------------------|
| Name: <i>(last, first, middle)</i> | Date of Marriage: | Date of Divorce/Separation/Widowed: |
| Address: <i>(street, city, state, zip code and county)</i> | | |
| Has this previous spouse/domestic partner ever been convicted of any crimes: <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

Children: *If you have more than six (6) children, please use the bottom of the next page and answer the same questions.*

| | | | | |
|---|---|-------------------|------------|-----------------------|
| A. Child's Name: <i>(last, first)</i> | Age/DOB: | | | |
| Address: <i>(street, city, state, zip code and county)</i> | | | | |
| Other Parent's Name: <i>(last, first)</i> | | | | |
| Do you have custody: <input type="checkbox"/> Yes <input type="checkbox"/> No | If no, what is the Name and Relation of the person who has custody of the child: <i>(e.g., grandmother, aunt, god-parent)</i> | | | |
| Are you ordered to pay support: <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, which county: | Amount per month: | Arrearage: | Date of Last Payment: |

- Children section continued on next page -

| | | | |
|--|--|---|--|
| B. Child's Name: <i>(last, first)</i> | | Age/DOB: | |
| Address: <i>(street, city, state, zip code and county)</i> | | | |
| Other Parent's Name: <i>(last, first)</i> | | | |
| Do you have custody: | | If no, what is the Name and Relation of the person who has custody of the child: <i>(e.g., grandmother, aunt, god-parent)</i> | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| Are you ordered to pay support: | | If yes, which county: | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| Amount per month: | | Arrearage: | |
| | | | |
| Date of Last Payment: | | | |

| | | | |
|--|--|---|--|
| C. Child's Name: <i>(last, first)</i> | | Age/DOB: | |
| Address: <i>(street, city, state, zip code and county)</i> | | | |
| Other Parent's Name: <i>(last, first)</i> | | | |
| Do you have custody: | | If no, what is the Name and Relation of the person who has custody of the child: <i>(e.g., grandmother, aunt, god-parent)</i> | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| Are you ordered to pay support: | | If yes, which county: | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| Amount per month: | | Arrearage: | |
| | | | |
| Date of Last Payment: | | | |

| | | | |
|--|--|---|--|
| D. Child's Name: <i>(last, first)</i> | | Age/DOB: | |
| Address: <i>(street, city, state, zip code and county)</i> | | | |
| Other Parent's Name: <i>(last, first)</i> | | | |
| Do you have custody: | | If no, what is the Name and Relation of the person who has custody of the child: <i>(e.g., grandmother, aunt, god-parent)</i> | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| Are you ordered to pay support: | | If yes, which county: | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| Amount per month: | | Arrearage: | |
| | | | |
| Date of Last Payment: | | | |

| | | | |
|--|--|---|--|
| E. Child's Name: <i>(last, first)</i> | | Age/DOB: | |
| Address: <i>(street, city, state, zip code and county)</i> | | | |
| Other Parent's Name: <i>(last, first)</i> | | | |
| Do you have custody: | | If no, what is the Name and Relation of the person who has custody of the child: <i>(e.g., grandmother, aunt, god-parent)</i> | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| Are you ordered to pay support: | | If yes, which county: | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| Amount per month: | | Arrearage: | |
| | | | |
| Date of Last Payment: | | | |

| | | | |
|--|--|---|--|
| F. Child's Name: <i>(last, first)</i> | | Age/DOB: | |
| Address: <i>(street, city, state, zip code and county)</i> | | | |
| Other Parent's Name: <i>(last, first)</i> | | | |
| Do you have custody: | | If no, what is the Name and Relation of the person who has custody of the child: <i>(e.g., grandmother, aunt, god-parent)</i> | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| Are you ordered to pay support: | | If yes, which county: | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| Amount per month: | | Arrearage: | |
| | | | |
| Date of Last Payment: | | | |

Family Members - Please list Parents, Step-Parents, Brothers and Sisters, include Step and Half Siblings. If more than 10 individuals, please use additional paper, providing the same information (name, relationship, address, and phone number).

| | | | | | |
|----------------------|--------|-------|---|--|--------|
| Name: | Last | First | Relationship: (mother, father, stepmother, brother, etc.) | | |
| | | | Father | | |
| Address: | Street | City | State | ZipCode | Phone: |
| Father's Occupation: | | | | Has father ever been arrested: | |
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

| | | | | | |
|------------------------------------|--------|-------|---|--|--------|
| Name: (Include Maiden Name) | Last | First | Relationship: (mother, father, stepmother, brother, etc.) | | |
| | | | Mother | | |
| Address: | Street | City | State | ZipCode | Phone: |
| Mothers's occupation: | | | | Has mother ever been arrested: | |
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

| | | | | | |
|---------------------------------|--------|-------|---|--|--------|
| Name: | Last | First | Relationship: (mother, father, stepmother, brother, etc.) | | |
| | | | | | |
| Address: | Street | City | State | ZipCode | Phone: |
| Occupation of above individual: | | | | Has individual above ever been arrested: | |
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

| | | | | | |
|---------------------------------|--------|-------|---|--|--------|
| Name: | Last | First | Relationship: (mother, father, stepmother, brother, etc.) | | |
| | | | | | |
| Address: | Street | City | State | Zip Code | Phone: |
| Occupation of above individual: | | | | Has individual above ever been arrested: | |
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

| | | | | | |
|---------------------------------|--------|-------|---|--|--------|
| Name: | Last | First | Relationship: (mother, father, stepmother, brother, etc.) | | |
| | | | | | |
| Address: | Street | City | State | ZipCode | Phone: |
| Occupation of above individual: | | | | Has individual above ever been arrested: | |
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

| | | | | | |
|---------------------------------|--------|-------|---|--|--------|
| Name: | Last | First | Relationship: (mother, father, stepmother, brother, etc.) | | |
| | | | | | |
| Address: | Street | City | State | ZipCode | Phone: |
| Occupation of above individual: | | | | Has individual above ever been arrested: | |
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

| | | | | | |
|---------------------------------|--------|-------|---|--|--------|
| Name: | Last | First | Relationship: (mother, father, stepmother, brother, etc.) | | |
| | | | | | |
| Address: | Street | City | State | ZipCode | Phone: |
| Occupation of above individual: | | | | Has individual above ever been arrested: | |
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

| | | | | | |
|---------------------------------|--------|-------|---|--|--------|
| Name: | Last | First | Relationship: (mother, father, stepmother, brother, etc.) | | |
| | | | | | |
| Address: | Street | City | State | ZipCode | Phone: |
| Occupation of above individual: | | | | Has individual above ever been arrested: | |
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

| | | | | |
|---------------------------------|--------|-------|--|---------|
| Name: | Last | First | Relationship: <i>(mother, father, stepmother, brother, etc.)</i> | |
| Address: | Street | City | State | ZipCode |
| Occupation of above individual: | | | Has individual above ever been arrested: <input type="checkbox"/> Yes <input type="checkbox"/> No | |

| | | | | |
|---------------------------------|--------|-------|--|---------|
| Name: | Last | First | Relationship: <i>(mother, father, stepmother, brother, etc.)</i> | |
| Address: | Street | City | State | ZipCode |
| Occupation of above individual: | | | Has individual above ever been arrested: <input type="checkbox"/> Yes <input type="checkbox"/> No | |

Associations

| | |
|--|--|
| Are you now, or have you ever been, a gang member: <input type="checkbox"/> No <input type="checkbox"/> Yes, If yes, what was/is the name of the gang: | |
| What was your rank in the gang: | How many years have you been or were you a gang member: Years |
| List any other social groups or organizations of which you are a member (e.g., church, sport team, Kiwanis, Masons, etc.) | |

Residence

| | | | | |
|--|--|---|--|---|
| With whom were you living at the time the crime was committed: | | | | |
| <input type="checkbox"/> Alone | <input type="checkbox"/> With Parent(s) | <input type="checkbox"/> With Children(s) | <input type="checkbox"/> With Grandparents | <input type="checkbox"/> With Spouse/Domestic Partner |
| <input type="checkbox"/> With Spouse/Domestic Partner & Children | | <input type="checkbox"/> Other (specify): _____ | | |
| With whom are you currently living: | | | | |
| <input type="checkbox"/> Alone | <input type="checkbox"/> With Parent(s) | <input type="checkbox"/> With Children(s) | <input type="checkbox"/> With Grandparents | <input type="checkbox"/> With Spouse/Domestic Partner |
| <input type="checkbox"/> With Spouse/Domestic Partner & Children | | <input type="checkbox"/> Other (specify): _____ | | |
| Type of Residence: | | | | |
| <input type="checkbox"/> Homeless | <input type="checkbox"/> House | <input type="checkbox"/> Trailer | <input type="checkbox"/> Apartment | <input type="checkbox"/> Room |
| <input type="checkbox"/> Other (specify): _____ | | | | |
| Type of Costs: | | | | |
| <input type="checkbox"/> Own/Mortgage | <input type="checkbox"/> Rent | <input type="checkbox"/> No Cost | <input type="checkbox"/> Subsidized | |
| <input type="checkbox"/> Other (specify): _____ | | | | |
| How much do YOU pay for housing per month: \$ | How long have you lived at your current address: Yrs | Months | How many times have you moved over the past 2 years: | |

Individuals living with you at your **current** address:

| | | | | |
|--------------|------|-------|------|---|
| Name: | Last | First | Age: | Relationship: <i>(step-son, spouse, etc.)</i> |
| Name: | Last | First | Age: | Relationship: <i>(step-son, spouse, etc.)</i> |
| Name: | Last | First | Age: | Relationship: <i>(step-son, spouse, etc.)</i> |
| Name: | Last | First | Age: | Relationship: <i>(step-son, spouse, etc.)</i> |

| |
|---|
| Names of other cities, states or countries in which you have lived: |
|---|

Education:

| | | | | | | |
|--------------------------|---|-------|------|--|------------------------------|-------------------------------------|
| Highest grade completed: | <input checked="" type="checkbox"/> <input type="checkbox"/> | Year: | GED: | <input type="checkbox"/> Yes, year - _____ | <input type="checkbox"/> No | <input checked="" type="checkbox"/> |
| | | | | <input type="checkbox"/> Working on it | <input type="checkbox"/> N/A | <input type="checkbox"/> |

| If, non-HS Graduate Reason for Leaving | (High School/Post H.S.) Last School(s) Attended | Location | |
|---|--|----------|-------|
| | | City | State |
| | | | |
| | | | |

List any learning difficulties or problems (e.g. special education, suspension, expelled) you had in school:

List any Licenses/Certifications/Vocational & Technical Certificates:

List any Special Skills Training you have had (e.g., martial arts, weapons):

Military History

| Branch | | | |
|---|---|---|--|
| <input type="checkbox"/> None (Skip to Physical Health) | <input type="checkbox"/> National Guard (Army) | <input type="checkbox"/> National Guard (Air Force) | <input type="checkbox"/> Reserves (any branch) |
| <input type="checkbox"/> Navy | <input type="checkbox"/> Army | <input type="checkbox"/> Air Force | <input type="checkbox"/> Marines |
| <input type="checkbox"/> Coast Guard | <input type="checkbox"/> Other (specify): _____ | | |

| Type of Discharge | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> Uncharacterized | <input type="checkbox"/> Conditions other than Honorable | <input type="checkbox"/> Bad Conduct |
| <input type="checkbox"/> Entry Level Separation | <input type="checkbox"/> Undesirable | <input type="checkbox"/> Dishonorable |
| <input type="checkbox"/> General Under Honorable Conditions | <input type="checkbox"/> Other (specify): _____ | |

| | | | |
|-----------------|-----------------|---------------|---|
| Admission Date: | Discharge Date: | Highest Rank: | Are you receiving benefits: <input type="checkbox"/> Yes <input type="checkbox"/> No |
|-----------------|-----------------|---------------|---|

Disciplinary/Special Training/Additional Comments:

Military History

Physical Health - Current Status:

Good Fair Poor Disabled

| | | | | | |
|--------------------|---|-------------------------|--------------------|---|-------------------------|
| Medical condition: | <input checked="" type="checkbox"/> <input type="checkbox"/> | Condition began (Date): | Medical condition: | <input checked="" type="checkbox"/> <input type="checkbox"/> | Condition began (Date): |
| Medical condition: | <input checked="" type="checkbox"/> <input type="checkbox"/> | Condition began (Date): | Medical condition: | <input checked="" type="checkbox"/> <input type="checkbox"/> | Condition began (Date): |

| Current | | | How Often | Current | | | How Often |
|---------------|--------|---|-----------|---------------|--------------------------|---|-----------|
| Medication(s) | Dosage | <input checked="" type="checkbox"/> <input type="checkbox"/> | | Medication(s) | Dosage | <input checked="" type="checkbox"/> <input type="checkbox"/> | |
| | | <input type="checkbox"/> | | | <input type="checkbox"/> | | |
| | | <input type="checkbox"/> | | | <input type="checkbox"/> | | |
| | | <input type="checkbox"/> | | | <input type="checkbox"/> | | |
| | | <input type="checkbox"/> | | | <input type="checkbox"/> | | |

In Case of an Emergency, who should be contacted:

| | |
|-------------------|----------------------------|
| Name: Last | Phone: (include area code) |
|-------------------|----------------------------|

What is the name of the doctor(s) who prescribed the medications you previously listed:

| | | |
|---|---|----------------------------|
| Name: Last First | <input type="checkbox"/> <input type="checkbox"/> | Phone: (include area code) |
| Prescribing Doctor's Location: (clinic/hospital, address, city/state) | | |

| | | |
|---|---|----------------------------|
| Name: Last First | <input type="checkbox"/> <input type="checkbox"/> | Phone: (include area code) |
| Prescribing Doctor's Location: (clinic/hospital, address, city/state) | | |

| | | |
|---|---|----------------------------|
| Name: Last First | <input type="checkbox"/> <input type="checkbox"/> | Phone: (include area code) |
| Prescribing Doctor's Location: (clinic/hospital, address, city/state) | | |

| |
|-----------|
| Comments: |
|-----------|

Are you presently under a doctor's care: Yes, continue No, if no skip to Mental Health Section

| | | |
|---|---|----------------------------|
| Name: Last First | <input type="checkbox"/> <input type="checkbox"/> | Phone: (include area code) |
| Doctor's Location: (clinic/hospital, address, city/state) | | |

| | | |
|---|---|----------------------------|
| Name: Last First | <input type="checkbox"/> <input type="checkbox"/> | Phone: (include area code) |
| Doctor's Location: (clinic/hospital, address, city/state) | | |

| | | |
|---|---|----------------------------|
| Name: Last First | <input type="checkbox"/> <input type="checkbox"/> | Phone: (include area code) |
| Doctor's Location: (clinic/hospital, address, city/state) | | |

Mental Health

Have you ever been examined or treated by a psychiatrist, psychologist, counselor or therapist: Yes No

| |
|--|
| If Yes, please list the mental health issues involved: |
|--|

| |
|--|
| Have you ever been a victim of any of the following: (check any/all that apply) |
| <input type="checkbox"/> Physical Abuse or Neglect <input type="checkbox"/> Sexual Abuse <input type="checkbox"/> Emotional Abuse or Neglect |

Have you ever attempted suicide: Yes, if yes, continue No, if no, skip to next question

| | |
|--------------------------|------------------------------|
| Date of Suicide Attempt: | Method of Attempted Suicide: |
| Date of Suicide Attempt: | Method of Attempted Suicide: |
| Date of Suicide Attempt: | Method of Attempted Suicide: |

Please check illness for which you have received a clinical diagnoses from a licensed mental health practitioner (check all that apply):

| | | | |
|---|--|---|---|
| <input type="checkbox"/> Major Depression | <input type="checkbox"/> Borderline Personality Disorder | <input type="checkbox"/> Posttraumatic Stress Disorder | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Panic Disorder | <input type="checkbox"/> No Clinical Diagnoses have been made | <input type="checkbox"/> Anxiety Disorder |
| <input type="checkbox"/> Schizoaffective Disorder | <input type="checkbox"/> Other (specify): _____ | | |

| Current | | | How Often | Current | | | How Often |
|---------------|--------|--------------------------|-----------|---------------|--------|--------------------------|-----------|
| Medication(s) | Dosage | V | | Medication(s) | Dosage | V | |
| | | <input type="checkbox"/> | | | | <input type="checkbox"/> | |
| | | <input type="checkbox"/> | | | | <input type="checkbox"/> | |
| | | <input type="checkbox"/> | | | | <input type="checkbox"/> | |
| | | <input type="checkbox"/> | | | | <input type="checkbox"/> | |

What is the name of the doctor(s) who prescribed the above medications:

| | | | | |
|---|------|-------|-------------------------------|----------------------------|
| Name: | Last | First | V <input type="checkbox"/> | Phone: (include area code) |
| Prescribing Doctor's Location: (clinic/hospital, address, city/state) | | | | |

| | | | | |
|---|------|-------|-------------------------------|----------------------------|
| Name: | Last | First | V <input type="checkbox"/> | Phone: (include area code) |
| Prescribing Doctor's Location: (clinic/hospital, address, city/state) | | | | |

| | | | | |
|---|------|-------|-------------------------------|----------------------------|
| Name: | Last | First | V <input type="checkbox"/> | Phone: (include area code) |
| Prescribing Doctor's Location: (clinic/hospital, address, city/state) | | | | |

Are you presently in Counseling: Yes, if yes, continue No, if no, skip to Mental Health Treatment Section

| | | | | |
|---|------|-------|-------------------------------|--|
| Name: | Last | First | V <input type="checkbox"/> | Counselor's Phone: (include area code) |
| Counselor's Location : (clinic/hospital, address, city/state) | | | | |

| | | | | |
|---|------|-------|-------------------------------|--|
| Name: | Last | First | V <input type="checkbox"/> | Counselor's Phone: (include area code) |
| Counselor's Location : (clinic/hospital, address, city/state) | | | | |

| | | | | |
|---|------|-------|-------------------------------|--|
| Name: | Last | First | V <input type="checkbox"/> | Counselor's Phone: (include area code) |
| Counselor's Location : (clinic/hospital, address, city/state) | | | | |

| |
|-----------|
| Comments: |
|-----------|

Mental Health Treatment

Please list any Mental Health Treatment that you have received: (if none, skip to substance abuse section)

| | | | |
|--|---------------|-------------|--|
| Facility/Program: <input type="checkbox"/> <input checked="" type="checkbox"/> | | | Was treatment court ordered: <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Location : | | | |
| Type of Treatment: <input type="checkbox"/> Out-Patient <input type="checkbox"/> In-Patient <input type="checkbox"/> CBCF House <input type="checkbox"/> Intensive Out-Patient <input type="checkbox"/> Halfway House <input type="checkbox"/> Other (specify): _____ | | | |
| Treatment for: | Date Started: | Date Ended: | Successfully Completed: <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

| | | | |
|--|---------------|-------------|--|
| Facility/Program: <input type="checkbox"/> <input checked="" type="checkbox"/> | | | Was treatment court ordered: <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Location: | | | |
| Type of Treatment: <input type="checkbox"/> Out-Patient <input type="checkbox"/> In-Patient <input type="checkbox"/> CBCF House <input type="checkbox"/> Intensive Out-Patient <input type="checkbox"/> Halfway House <input type="checkbox"/> Other (specify): _____ | | | |
| Treatment for: | Date Started: | Date Ended: | Successfully Completed: <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

| | | | |
|--|---------------|-------------|--|
| Facility/Program: <input type="checkbox"/> <input checked="" type="checkbox"/> | | | Was treatment court ordered: <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Location: | | | |
| Type of Treatment: <input type="checkbox"/> Out-Patient <input type="checkbox"/> In-Patient <input type="checkbox"/> CBCF House <input type="checkbox"/> Intensive Out-Patient <input type="checkbox"/> Halfway House <input type="checkbox"/> Other (specify): _____ | | | |
| Treatment for: | Date Started: | Date Ended: | Successfully Completed: <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

| |
|---|
| Comments Regarding Mental Health Treatment: |
|---|

Substance Abuse

| Substance | How Often & How Much Used | | | Method(s) of Use | Age 1st Used | Date Last Used | Use at time of Offense | | | |
|-----------------|---------------------------|---------|--------------|---------------------|--------------|----------------|------------------------|--------|-----|----|
| | Less than 12 times/yr | | 2 times/wk | | | | Oral | Inhale | Yes | No |
| | Past | Current | Heaviest Use | | | | | | | |
| Alcohol | | | | Inject/Subcutaneous | Smoke | | | | | |
| Amphetamine | | | | Other (specify): | | | | | | |
| Barbiturates | | | | | | | | | | |
| Marijuana | | | | | | | | | | |
| Ecstasy | | | | | | | | | | |
| LSD | | | | | | | | | | |
| Prescription | | | | | | | | | | |
| Crack Cocaine | | | | | | | | | | |
| Powder Cocaine | | | | | | | | | | |
| Methamphetamine | | | | | | | | | | |
| Heroin | | | | | | | | | | |
| Inhalants | | | | | | | | | | |
| Opiates | | | | | | | | | | |
| None | | | | | | | | | | |
| Other: | | | | | | | | | | |

Have you had prior substance abuse treatment?

Yes, continue No (if no, skip to Financial Status)

Substance Abuse Treatment

| | | | |
|--|---------------|--|--|
| Facility/Program: <input checked="" type="checkbox"/> | | Was treatment court ordered: <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Location: | | | |
| Type of Treatment: <input type="checkbox"/> Out-Patient <input type="checkbox"/> In-Patient <input type="checkbox"/> CBCF <input type="checkbox"/> Intensive Out-Patient <input type="checkbox"/> Halfway House <input type="checkbox"/> Other (specify): _____ | | | |
| Treatment for: | Date Started: | Date Ended: | Successfully Completed: <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

| | | | |
|--|---------------|--|--|
| Facility/Program: <input checked="" type="checkbox"/> | | Was treatment court ordered: <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Location: | | | |
| Type of Treatment: <input type="checkbox"/> Out-Patient <input type="checkbox"/> In-Patient <input type="checkbox"/> CBCF <input type="checkbox"/> Intensive Out-Patient <input type="checkbox"/> Halfway House <input type="checkbox"/> Other (specify): _____ | | | |
| Treatment for: | Date Started: | Date Ended: | Successfully Completed: <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

Have you been involved with any other case managers/case workers at any other social service agencies (e.g., Children's Services, Veteran's Administration)?

Yes (if yes, please identify the date(s) of service, agency & address below) No (if no, skip to financial status questions below)

| | | |
|--------------------------------------|-------------|-------------------------------------|
| Date Started: | Date Ended: | Agency: (also name of case manager) |
| Agency Address: (address,city,state) | | |

| | | | |
|--|---------------|--|--|
| Facility/Program: <input checked="" type="checkbox"/> | | Was treatment court ordered: <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Location: | | | |
| Type of Treatment: <input type="checkbox"/> Out-Patient <input type="checkbox"/> In-Patient <input type="checkbox"/> CBCF <input type="checkbox"/> Intensive Out-Patient <input type="checkbox"/> Halfway House <input type="checkbox"/> Other (specify): _____ | | | |
| Treatment for: | Date Started: | Date Ended: | Successfully Completed: <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

Current Situation:

Do you currently have a substance abuse problem?

Yes No (if no, skip to Financial Status)

Do you want further substance abuse treatment?

Yes No (if no, skip to Financial Status)

Financial Status

| Primary Source of Income | | Total Income Per Month <input type="checkbox"/> <input type="checkbox"/> | List Assets & Values <i>E.g., bank accts, reale state, furniture, vehicles, electronics, personal items, jewelry, etc.</i> | List Debts & Values <i>E.g., unpaid bills-rent, utilities, child support, medical bills, outstanding loans, etc.</i> | List Expenses per Month <i>E.g., rent/mortgage, utilities, child support, car payment, monthly bills, etc.</i> |
|--|--|---|---|---|---|
| At Time of Offense <input checked="" type="checkbox"/> <input type="checkbox"/> | Current <input type="checkbox"/> <input type="checkbox"/> | | | | |
| <input type="checkbox"/> Employment <input type="checkbox"/> Worker's Compensation <input type="checkbox"/> SSD/SSI <input type="checkbox"/> Pension/Retirement <input type="checkbox"/> Government Assistance/welfare/food stamps <input type="checkbox"/> Child Support/Alimony <input type="checkbox"/> Family/Friends <input type="checkbox"/> Other (specify): _____ | <input type="checkbox"/> Employment <input type="checkbox"/> Worker's Compensation <input type="checkbox"/> SSD/SSI <input type="checkbox"/> Pension/Retirement <input type="checkbox"/> Government Assistance/welfare/food stamps <input type="checkbox"/> Child Support/Alimony <input type="checkbox"/> Family/Friends <input type="checkbox"/> Other (specify): _____ | | | | |

| | | |
|--|----------------|------------------|
| Have you ever declared bankruptcy? <input type="checkbox"/> Yes <input type="checkbox"/> No (if no, skip to "Employment" section) | Date Declared: | Amount Declared: |
| Location: (include court/jurisdiction and city/state) | | |

Employment

| Employment Status at Time of Offense | | Current Employment Status | | If Unemployed Reason Not Employed | |
|--|---|--|---|---|--|
| <input type="checkbox"/> Full-Time | <input type="checkbox"/> Temporary Agency | <input type="checkbox"/> Full-Time | <input type="checkbox"/> Temporary Agency | <input type="checkbox"/> Homemaker | <input type="checkbox"/> Laid-Off |
| <input type="checkbox"/> Part-Time | <input type="checkbox"/> Unemployed | <input type="checkbox"/> Part-Time | <input type="checkbox"/> Unemployed | <input type="checkbox"/> Student | <input type="checkbox"/> Incarcerated |
| <input type="checkbox"/> Self-Employed | <input type="checkbox"/> Under the Table | <input type="checkbox"/> Self-Employed | <input type="checkbox"/> Under the Table | <input type="checkbox"/> Retired | <input type="checkbox"/> Limited Skills/ Training |
| <input type="checkbox"/> Seasonal | <input type="checkbox"/> Never Worked | <input type="checkbox"/> Seasonal | <input type="checkbox"/> Never Worked | <input type="checkbox"/> Disabled | |
| <input type="checkbox"/> Other (specify below): | <input type="checkbox"/> Laid-Off | <input type="checkbox"/> Other (specify below): | <input type="checkbox"/> Laid-Off | <input type="checkbox"/> Other (specify): | |

Employment History

| Employer <i>List Most Recent/Current Employer first: (name, address)</i> | Job Title | Start Date | End Date | Hourly Wage | Avg. Hours per Week | If No Longer Employed | |
|---|-----------|------------|----------|-------------|---------------------|---|--|
| | | | | | | Reason for Leaving <i>(e.g., quit, fired, disabled, lay-off, incarcerated, etc.)</i> | |
| <input type="checkbox"/> | | | | | | <input type="checkbox"/> | |
| <input type="checkbox"/> | | | | | | <input type="checkbox"/> | |
| <input type="checkbox"/> | | | | | | <input type="checkbox"/> | |
| <input type="checkbox"/> | | | | | | <input type="checkbox"/> | |
| <input type="checkbox"/> | | | | | | <input type="checkbox"/> | |

Current/Most Recent Employer Contact Information:

| | |
|--|------------------------------|
| Employee Address (street, city, state and zip code): | |
| Supervisor: | Phone (including area code): |

Offense

Describe in your own words your crime or offense. Include any reason you had for committing the crime or offense and how you feel about what you did.

Offense - continued

List the First and Last Name of the People who were also Involved in Your Offense:

Prior Record

List any prior arrests, tickets, or summons, juvenile & adult: *(include major traffic tickets)*

| Date | Offense/Charges | Location <i>(city/county/state)</i> | Outcome <i>(sentence; include institution number)</i> |
|------|-----------------|--|--|
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Investigator's Comments:

| | |
|-----------------------|-------|
| Applicant/Inmate: | Date: |
| Investigator/Witness: | Date: |