APPLICATION FOR:
DUI TREATMENT COURT
Fee due with application - $ 300
Criminal complaint must be attached

Name: ______________________________________ Maiden Name/other ______________________

Address: ____
Street City State Zip Code

Email Address: ____

County where you reside: ☐Blair Other: _______________ Telephone #: ____________________

Date of Birth: ______________________ Social Security Number: __________________________

Case Number: ______________________ Date of Offense: ________________________________

Attorney: ☐Public Defender Private Attorney: _________________ Telephone: _________________

Employer: ________________________ Employer Address: ______________________________

I plan to request work release while incarcerated at Blair County Prison ☐Yes ☐No

D.U.I. OFFENSE		FEE
☐ 2ND .25 or higher/Refusal of Breath/Refusal of Blood with Warrant/Drugs		$300 with application
After sentencing:		
10 days jail	80 days electronic monitoring (EM)	$100/month EM administration fee
☐ 3RD .16 or higher/Refusal of Breath/ Refusal of Blood with Warrant/Drugs		$300 with application
After sentencing:		
90 days jail	275 days electronic monitoring (EM)	$100/month EM administration fee

Electronic Monitoring is required as part of your sentence. Telephone service must be installed and functioning at least 15 days prior to your court date. Failure to have telephone service at the time of scheduled monitoring will constitute cause for arrest and confinement to the Blair County Prison for violating conditions of the program.

I verify that the statements made in the foregoing application are true and correct to the best of my knowledge, information and belief. I understand that false statements herein are made subject to the penalties of 18 PA C.S.A. SEC. 4909 relating to Unsworn Falsification to Authorities.

______________________________________ ______________________________

DEFENDANT'S SIGNATURE DATE

Bring application with fee to your Preliminary Conference or mail to:
Blair Drug & Alcohol Partnerships, 3001 Fairway Drive, Suite D, Altoona, PA 16602
(in Fairway Centre between Pennsylvania Department of Environmental Protection & CareerLink)

BLAIR COUNTY DRUG AND ALCOHOL PROGRAM, INC CONFIDENTIALITY AUTHORIZATION TO RELEASE INFORMATION

Individual's Name: ✕ ______________________________

I hereby authorize: **Blair County Drug and Alcohol Program, Inc. 3001 Fairway Drive, Suite D, Altoona, PA 16602**
Name of Organization, Person, or Title

to release the following information to:

Blair County Adult Probation & Parole Office
Name of Organization, Person, or Title

At: **Blair County Court House, 423 Allegheny Street, Suite 330, Hollidaysburg, PA 16648 814-693-3190**
Address

The following information pertaining to MYSELF.

THE INFORMATION WHICH MAY BE RELEASED IS LIMITED STRICTLY TO THE FOLLOWING:

( ) PCPC Summary Sheet
( ) ASAM Summary Sheet
( ) Psychosocial/diagnostic summary
( ) Emergency Contact
( ) Physical Description
( ) Liability Information
(X) Attendance
( ) Progress on objectives
( ) Legal System (type of program, summary of progress, Type/frequency of relapse and prognosis
( ) Preliminary Diagnosis

Reason for the Disclosure: **Coordination of Services**

- **I understand the duration of this authorization is for no longer than one year unless I specify a date, event, or condition upon which it will expire sooner.**
  Specify date, event, or condition ONLY if consent expires sooner than 1 year; otherwise specify NA: ____________________
- **I understand that this authorization may be cancelled at any time by a verbal or written request unless I have been mandated into treatment as a result of a criminal proceeding. Information may have been previously released prior to the cancellation.**
- **I understand that I may refuse to sign this authorization; my refusal will not prevent me from receiving services; my refusal will prevent the treatment providers from sharing information that may be beneficial to my treatment.**
- **I have read and understand the intent of this authorization.**
- ✕ **I have been offered and ☐ accepted ☐ refused a copy of this form.**

✕ ______________________________ Individual's Signature

______________________________ Witness to Signature

✕ ______________________________ Date

______________________________ Date

A copy of the Authorization shall be deemed valid as original. ***To be valid, this Authorization must be signed and dated.***

PROHIBITION OF REDISCLOSURE: The information has been disclosed to you from records whose confidentiality is protected by State and Federal Law. Regulations prohibit you from making any further disclosures of this information except with the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. A general release of medical or other information is NOT sufficient for this purpose. Federal rules do not allow any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient.