

**Allen County Community Corrections
Defendant Information**

Date: _____

Revised 08/04/20

LAST NAME _____	FIRST NAME _____	MIDDLE _____	
DOB _____	SSN _____	HEIGHT _____	RACE _____
WEIGHT _____	GENDER _____	HAIR _____	EYES _____
PLACE OF BIRTH _____	US CITIZEN YES / NO	<input type="checkbox"/> VIOLENT OFFENDER	
		<input type="checkbox"/> SEX OFFENDER	
Scars / Marks / Tattoos _____			
Alerts / Warnings _____			

<input type="radio"/> <i>Zero Tolerance for</i> _____ <i>Approved by</i> _____ <i>on</i> _____
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Spillman Number _____	DOC # _____
MARITAL STATUS: Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/>	
LAST GRADE COMPLETED _____	<input type="checkbox"/> GED <input type="checkbox"/> DIPLOMA
Prior Misdemeanors Yes <input type="checkbox"/> No <input type="checkbox"/>	Were any drug/alcohol related? Yes <input type="checkbox"/> No <input type="checkbox"/>
Prior Felonies Yes <input type="checkbox"/> No <input type="checkbox"/>	Were any drug/alcohol related? Yes <input type="checkbox"/> No <input type="checkbox"/>
Previously supervised by: ACCC <input type="checkbox"/> Probation <input type="checkbox"/> Parole <input type="checkbox"/>	
Number of times in DOC _____	US VETERAN Yes / No

ADDRESS _____	COUNTY _____	
CITY _____	STATE _____	ZIP CODE _____
PRIMARY PHONE # _____	2ND PHONE # _____	Region _____
<u>PERSONS LIVING IN THE RESIDENCE</u>	<u>RELATIONSHIP</u>	
OWN / RENT: _____	D.O.B. / AGE: _____	
_____	_____	
_____	_____	
_____	_____	
Number of dependents: _____		

ALL PETS IN RESIDENCE:

EMERGENCY CONTACT

NAME _____ RELATIONSHIP _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

PHONE # (S) _____

PROPERTY RELEASE DESIGNEE

NAME _____ RELATIONSHIP _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

PHONE # (S) _____

UNEMPLOYED EMPLOYER / SCHOOL / COLLEGE _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

PHONE # _____ Region _____ Date Verified _____

DATE HIRED _____ MODE OF TRAVEL _____ PART TIME FULL TIME

SUPERVISOR'S NAME _____ PHONE # _____

WAGE/ ANNUAL WAGE _____ PAID WEEKLY BI-WEEKLY MONTHLY

UNEMPLOYED EMPLOYER / SCHOOL / COLLEGE _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

PHONE # _____ Region _____ Date Verified _____

DATE HIRED _____ MODE OF TRAVEL _____ PART TIME FULL TIME

SUPERVISOR'S NAME _____ PHONE # _____

WAGE/ ANNUAL WAGE _____ PAID WEEKLY BI-WEEKLY MONTHLY

IDENTIFICATION TYPE:

VALID SUSPENDED NEVER RECVD

DRIVER'S LICENSE

GREEN CARD

STATE ID

PASSPORT

LEARNER'S PERMIT

EXPIRATION DATE _____ STATE _____

VEHICLE COLOR _____ YEAR _____ PLATE # _____

VEHICLE MAKE _____ VEHICLE TYPE _____

MEDICAL DIAGNOSES: _____

BEING TREATED BY PHYSICIAN: YES ___ NO ___

Do you currently have health insurance coverage? YES ___ NO ___

Do you have a medical condition(s) that you would like an emergency medical provider to know? Yes ___ No ___

If yes, Please explain: _____

Do you have any life-threatening allergies that require accommodation? YES ___ NO ___

If yes, Please explain: _____

Note: You must provide medical verification of this life-threatening allergy and specific medical accommodation instructions within 24 hours of your intake onto supervision with ACCC. Please provide this medical verification to your assigned case manager.

Do you have an e-mail address? YES ___ NO ___

If yes, list your e-mail address _____

Need medical documentation with diagnosis / restriction Verified on _____ by _____

PLEASE LIST ANY MENTAL HEALTH DISORDER YOU HAVE BEEN DIAGNOSED WITH:

HAVE YOU EVER RECEIVED MENTAL HEALTH TREATMENT FOR THESE: YES/NO

If your answer is yes, what were you in treatment for (mark all that apply):

Anger Management | Did you successfully complete the program? Yes | No

Mental Health | Did you successfully complete the program? Yes | No

Family/Relationship Counseling | Did you successfully complete the program? Yes | No

HISTORY OF SUBSTANCE USE (Drugs and/or Alcohol) YES / NO

MOST COMMONLY USED SUBSTANCE/S (e.g. marijuana, alcohol, cocaine, etc.) _____

HAVE YOU EVER RECEIVED SUBSTANCE ABUSE TREATMENT YES / NO

If your answer is yes, mark all that apply:

Substance Use Outpatient | Did you successfully complete the program? Yes | No

Substance Abuse – Residential Treatment / Inpatient | Did you successfully complete the program? Yes | No

Halfway House | Did you successfully complete the program? Yes | No

Other _____ | Did you successfully complete the program? Yes | No

HAVE YOU EVER ATTENDED OR ARE YOU WILLING TO ATTEND SOBER SUPPORT MEETINGS (AA/NA/CR): YES / NO

HAVE YOU EVER FAILED A DRUG SCREEN: YES / NO

HAVE YOU USED ALCOHOL / DRUGS IN THE LAST: 2 weeks week 48 hours

LONGEST PERIOD OF TIME YOU HAVEN'T USED ALCOHOL / DRUGS:

more than one week one week 48 hours or less



**Allen County Community Corrections
Veteran's Questionnaire**

Name: _____ DOC #: _____

Last four of Social Security Number: _____ DOB: _____
(to be used by the Veteran's Affairs Office)

1. Have you ever served in the U.S. Armed Forces?

Yes No

2. Have you ever served in the U.S. National Guard or Reserves?

Yes No If yes, have you ever been deployed? Yes No

3. Which Branch(s) of the Armed Forces have you served?

- Army (including Army National Guard or Reserve)
- Navy (including Reserve)
- Marine Corps (including Reserves)
- Air Force (including Air National Guard and Reserve)
- Coast Guard (including Reserve)
- Other – specify _____

4. When did you first enter the Armed Forces?

Month: _____ Year: _____

5. When were you last discharged?

Month: _____ Year: _____

6. Altogether, how long did you serve in the Armed Forces?

Years: _____ Months: _____ Days: _____

7. What type of Discharge did you receive?

- | | |
|---|---|
| <input type="checkbox"/> Honorable | <input type="checkbox"/> Bad Conduct |
| <input type="checkbox"/> General (Honorable Conditions) | <input type="checkbox"/> Dishonorable |
| <input type="checkbox"/> General (without Honorable Conditions) | <input type="checkbox"/> Medical _____ |
| <input type="checkbox"/> Other than Honorable | <input type="checkbox"/> Other specify: _____ |

8. Have you ever received services from the VA Hospital?

Yes No

Cause # _____ Offense Level _____ Offense _____

Offense Level _____ Offense _____

I.C. Code _____ Received Code _____

Sentence Status _____ Violent Victim Schedule _____ Risk Level _____

Sentence Date _____ Max out Date _____

Judge _____ Probation/Parole Officer _____

Component _____ Start Date _____ End Date _____

Method of Referral _____ Referral Source _____

Sentence # Years _____ # Days _____ Case Manager _____

Sentencing Conditions

Previous Probation Supervision Previous Community Corrections Supervision

Cause # _____ Offense Level _____ Offense _____

Offense Level _____ Offense _____

I.C. Code _____ Received Code _____

Sentence Status _____ Violent Victim Schedule _____ Risk Level _____

Sentence Date _____ Max out Date _____

Judge _____ Probation/Parole Officer _____

Component _____ Start Date _____ End Date _____

Method of Referral _____ Referral Source _____

Sentence # Years _____ # Days _____ Case Manager _____

Sentencing Conditions

Previous Probation Supervision Previous Community Corrections Supervision

Restitution and Child Support Financial Obligations

ACCC Supervision Cause # _____

Participant ordered to pay Restitution: YES NO Amount: _____

Parental Status: Custodial Parent Non-Custodial Parent No Children No Dependent Children

Participant ordered to pay Child Support: YES NO Amount: _____

Confirmed in: Court Order Odyssey PSI

CTP / Re Entry

Legal Status Determined at the Time of Admission into the Problem Solving Court:

- Condition of Probation
- Condition of participation in a Community Corrections program under 11-12-1
- Condition of Community Transition Program under IC 11-10-11.5
- Condition of Parole
- Condition of Pre-Trial Diversion Program authorized by the Problem Solving Court
- Judgement if conviction withheld pending successful completion of the Problem Solving courts (Deferred)
