NOTICE TO DRUG/ALCOHOL DIVERSION APPLICANTS

If you are applying for the Juvenile Diversion program due to a drug/alcohol offense, you are required to complete the following steps. **Failure to comply may result in program denial.**

STEP 1: **Go to Recovery Unlimited between 2:00 P.M. and 5:00 P.M. ON THE DAY OF YOUR COURT APPEARANCE for a urinalysis test. Recovery Unlimited is located at 3835 W. Douglas Ave., Wichita, KS 67213. You must pay $20.00 for your UA at RECOVERY UNLIMITED (cash, credit or money order only).**

NOTE: **A positive UA result alone will not make you ineligible for diversion.**

STEP 2: Return your completed Diversion application form to the Juvenile Diversion Office within 24 hours of your first Court date.

1. Include a **$25.00** non-refundable application fee.

NOTE: The Application Fee must be in the form of a **Money order, cashier's check, or Attorney's trust account check,** made Payable to the "District Attorney." NO CASH OR PERSONAL CHECKS WILL BE ACCEPTED.

STEP 3: **Notify the Juvenile Diversion Office (phone 660-9777) of the location and date of your scheduled Drug and Alcohol Assessment, NO later than two (2) days from your first Court date. Your application request will be DENIED if you fail to report this information.**

NOTE: A certified Drug and Alcohol Counselor must complete the assessment. Attached are some places you may obtain your assessment, however, this list is not all-inclusive and the decision is yours where to go.

STEP 4: Sign a release of information to the District Attorney, Juvenile Diversion Office At your first visit with the Drug/Alcohol facility. **You must** have the results of Your Drug/Alcohol Assessment forwarded to the Juvenile Diversion Office, **NO** later than **nine (9) days** from your first Court date.

The Application **WILL NOT** be processed until the Application Fee is received.

Downtown
535 North Main Wichita, Kansas 67203

Office of the District Attorney
18th Judicial District of Kansas

Juvenile
1900 E Morris Wichita, Kansas 67211

APPLICATION FOR JUVENILE DRUG DIVERSION

Please fill in this form completely. Failure to provide requested information could result in the denial of your application. Completed applications must be returned to the Diversion Office with the $25.00 non-refundable application fee in the form of a money order made payable to the District Attorney's Office.

NOTE: The application and fee must be returned to the diversion office within 24 hours of the first initial appearance.

SECTION I: APPLICANT INFORMATION

Applicant's Name:

Date of Birth: ◯ Male ◯ Female SSN#

Current address:

City: State: Zip Code:

Race: Ethnicity: ◯ Hispanic ◯ Non-Hispanic Driver's License # and State:

Home phone: Cell phone: Email:

Current school: Grade: ☐ Graduated?

GED: completed ☐ in progress ☐ where?

Mother's Name:

Address:

City: State: Zip Code:

Home phone: Cell phone: Email:

Father's Name:

Address:

City: State: Zip Code:

Home phone: Cell phone: Email:

Guardian's Name: Relationship:

Address:

City: State: Zip Code:

Home phone: Cell phone: Email:

If you or your parent/guardian require an interpreter, you will be asked to provide your own.
Interpreters must be at least **18 years of age**, and **can NOT be a sibling** of the applicant.

FOR DIVERSION OFFICE USE ONLY

Case Number:		Charge:	
Returned Date:		Paid:	

SECTION II:
BACKGROUND INFORMATION

Please list all previous cities and/or states you have lived. If you need additional space please use a blank sheet of paper and attach to the application.

City	State	Dates lived there

Please list all law enforcement contact, including arrests, JIAC intakes, charges, citations (including traffic or tobacco tickets), agreements or orders to appear, prosecutions, convictions, expungements, pending cases and diversions or deferred prosecution agreements in Kansas or any other states. Please include the current charge for which you are applying for diversion. If you need additional space please use a blank sheet of paper and attach it to the application. **FAILURE TO DISCLOSE ALL LAW ENFORCEMENT CONTACT MAY RESULT IN YOUR DIVERSION APPLICATION BEING DENIED.**

Date of Incident	Law Enforcement Agency	Charge or Circumstances

Please list all current and previous counseling and treatment services you have received for alcohol, drug, emotional or psychological issues. Include DCCCA and SRS case management services. If you need additional space please use a blank sheet of paper and attach to the application.

Agency	Reason for Services	Dates Attended

If you entered any information in the table above, please complete an authorization form (last page) for each entry listed.

I hereby apply for status as a participant in the Diversion Program and request that the District Attorney and the Court temporarily delay trial against me in order to permit consideration of this application. I understand it is my responsibility to submit a diversion application in a prompt and timely fashion and within the guidelines set by the District Attorney and that it will be my responsibility to seek any continuance in order to provide the necessary time for my diversion application to receive a full and complete review by the District Attorney's Office. I understand if the District Attorney's Office is required to make a decision concerning my application prior to the office having an opportunity to make a full and complete review, my application request will be denied. I understand that the final decision to commence criminal proceedings or to defer prosecution in my case rests entirely with the District Attorney.

I authorize the District Attorney's Office to conduct an investigation to determine my suitability for this program. I understand that all records that I have authorized to be furnished to the District Attorney's Office in connection with this investigation will be kept confidential.

I authorize the District Attorney's Office to discuss information relating to my participation in the Diversion Program with any participating mental health agencies, social service agencies, law enforcement agencies, treatment providers, school personnel or laboratories as deemed necessary by my diversion coordinator. A false answer to or omission of an answer to any question in this application shall be grounds for recommendation against placement into this program or removal after placement in the program, in which case, the District Attorney will resume prosecution on the original charges.

I understand and agree that in the event it is learned I have falsified or omitted any part of the Application for Diversion, including, but not limited to, my listing of prior traffic and criminal offenses, it shall be considered a violation of my Agreement for Pre-Trial Diversion and I may be taken off Diversion. I agree that a criminal justice report, including, but not limited to, a Department of Justice report, KBI report, Police Department or Sheriff's Department report, and/or Department of Revenue report, may be admitted as evidence in any court, without foundation, to prove prior traffic or criminal offenses.

I understand that failure to respond to any question will render the application incomplete and the District Attorney's Office will not consider the application.

I declare (or verify, certify or state) under penalty of perjury under the laws of the State of Kansas that I have personally read or have had read to me this Application for Diversion and responses given and that all information contained in the foregoing application for the Pretrial Diversion Program is true and correct.

I authorize the District Attorney's Office to conduct a background check of my past employment and school records and I authorize my present and previous employers and schools to furnish the District Attorney's Office with any information they request. I further authorize the District Attorney's Office to contact government agencies and agencies under government contract and authorize those agencies to release all information they possess about me to the District Attorney's Office. I further authorize the District Attorney's Office to contact my liability insurance carrier and authorize my carrier to release any information they possess about me to the District Attorney's Office. I further authorize the District Attorney to send directly to me all copies of material sent to my attorney. If needed, I may be contacted directly by phone or in person without first getting my attorney's permission.

Executed on_____
Date Applicant's Signature

Executed on_____
Date Parent's Signature

Executed on_____
Date Parent's Signature

AUTHORIZATION FORM FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION
Office of the District Attorney, 18th Judicial District

Client Information:

Name: _____ SSN #: _____ DOB: _____

Address:_____

I,_____ hereby authorize _____
(Clients Name) (Treatment Facility)

to disclose records and information, including Protected Health Information(*PHI*),to the Office of the District Attorney and the 18th Judicial District Court, Wichita, Kansas. I further authorize the facility listed above to discuss matters related to these records and information with representatives of the Office of the District Attorney, for the purpose of assisting me in a legal matter per: 42 CFR part 2.
Name: _____

The type of information to be disclosed is as follows: case notes, assessments/evaluations, recommendations, admission history, progress in treatment, test results, aftercare plans and discharge summary related to diagnosis and treatment for any medical, psychiatric, psychological, emotional or drug/alcohol/substance abuse concerns for examination/treatment dates from _____to _____ .

This authorization will expire on_____ or upon the termination of the legal matter, but no later than one year from the date listed below.

* I understand I may revoke this authorization at any time by giving notification to the facility listed above. I further understand such revocation will have no effect on actions already taken in reliance on this form.
* I understand that if the person or entity that receives the described records and information is not subject to federal privacy regulations or other privacy laws, the records and information may be re-disclosed and no longer protected.
* I understand that treatment is not conditioned on my giving this authorization.
* I have read and understand this form. I am the patient listed or am authorized to act on behalf of the patient as the patient's personal representative. I also permit disclosure of the records upon presentation of a photocopy or facsimile copy of this form.

Signature of Client: _____ Date: _____

Signature of Representative: _____Date: _____

Printed Name of Representative: _____

Description of Representative~~s~~ Authority: _____

Representative~~s~~ Address:_____ Phone: _____
_____

*** Substance Abuse Treatment Records** are confidential and protected by federal law. Federal regulations (42 CFR part 2) prohibit you from making any further disclosure of this information except by the specific written consent of the person to which it pertains. A general authorization for the release of medical or other information is NOT sufficient for this purpose. Federal rules restrict the use of this information to criminally investigate or prosecute a patient.

Click Here to Print