

**NON-REMOVABLE MILLE LACS BAND OF CHIPPEWA INDIANS
COURT OF CENTRAL JURISDICTION**

**NOOJIMO'WIGAMIG INAAWANIDIWAG
(Family Healing to Wellness Court)**

District 1

District 2

District 3

In the Matter of:

Case File No. _____

Minor Child(ren).

Parent/Guardian.

PROGRAM APPLICATION

Parent/Guardian.

DATE OF APPLICATION: _____

1. PERSONAL INFORMATION

Full Legal Name: _____

Alias or Former Name: _____

Date of Birth: _____ Sex: _____

Tribal Membership: Mille Lacs Band Member None

Member of _____

Tribal Census Number: _____

Social Security Number: _____

Phone Number: _____ Alternate Phone Number: _____

Email Address: _____

Mailing Address:

Street Address or P.O. Box: _____

City: _____ State _____ Zip Code: _____

Residential Address: Same as mailing address.

Street Address: _____

City: _____ State _____ Zip Code: _____

Cohabitant Name: _____

Cohabitant's Relationship to Applicant: _____

Next of Kin: _____ Relationship: _____

Next of Kin's Phone Number: _____

2. CHIPS CASE INFORMATION

Are you the parent, guardian, or custodian of a child(ren) who is the subject of a Child In Need of Protection (CHIPS) case that is currently pending? No Yes Case Number _____

Attorney for current case: _____ Phone: _____

3. CRIMINAL COURT BACKGROUND

Are you currently on probation? Yes No

Are you currently on supervised release or parole? Yes No

If yes, name of your probation/parole officer: _____ Phone: _____

Have you ever been convicted of a violent crime? Yes No

Are you currently incarcerated? Yes No

Do you have any pending warrants for your arrest? Yes No

If yes, in what jurisdiction? _____

Do you have any pending criminal charges? Yes No

If yes, in what jurisdiction? _____

If yes, list current charges: _____

Case number: _____ Stage in court process: _____

Next court event: _____ Date: _____

4. HEALTH & SUBSTANCE ABUSE HISTORY

I have a problem with: Drugs Alcohol Both Are you an IV user? Yes No

Age at first use: _____ What did you use? _____ Method of use: _____

First drug of choice: _____ Age started: _____

Method of use: _____ Date last used: _____

Second drug of choice: _____ Age started: _____

Method of use: _____ Date last used: _____

Third drug of choice: _____ Age started: _____

Method of use: _____ Date last used: _____

Have you ever been treated for substance abuse problem? Yes No

Date of most recent treatment admission? _____

Number of previous substance abuse admissions? _____ Inpatient _____ Outpatient

Are you participating in a Medication-Assisted Treatment program? Yes No

Number of previous Minnesota admissions? _____ Inpatient _____ Outpatient

Please describe any diagnosis here: _____

Do you have any serious medical problems? Yes No

Please describe here: _____

Please describe any diagnosis here: _____

Are you currently on any prescription medication? Yes No

Please list medications here: _____

5. PERSONAL INFORMATION

Highest level of education completed? _____ High school diploma? Yes No

Do you have a GED? Yes No Would you like to earn your GED? Yes No

Do you have a valid driver's license? Yes No Are there any restrictions? Yes No

Please explain: _____

Do you have a vehicle or access to a vehicle? Yes No

Will transportation be a problem for you? Yes No

Do you have any special needs? Yes No If yes, please describe: _____

6. FINANCIAL AND EMPLOYMENT INFORMATION

Monthly income: \$ _____ Source of income: Wages Per Capita Other

Are you employed? Yes No Where? _____

Is your current income sufficient to pay your bills? Yes No

Do you have health insurance? Yes No Name of insurance carrier: _____

7. CHILD CARE NEEDS

Name of your child: _____ Date of Birth: _____

Name of your child: _____ Date of Birth: _____

Name of your child: _____ Date of Birth: _____

Do you currently have custody of these child(ren)? Yes No

Are you subject to any child support orders? Yes No

Do you owe any back child support? Yes No

8. OTHER NEEDS

Check those services that you are in immediate need of:

- Housing Food Heating Assistance Medical Care Dental Care
- Domestic Violence Information Job Assistance Education Assistance Cell Phone
- Pregnancy Care Driver's License Assistance Cultural Guidance/Support

9. PERSONAL GOALS

Please explain why you would like to enter the Family Healing to Wellness Court Program and what you hope to gain from it: _____

What do you like to do in your free time? _____

This application will not be considered for admission to the Family Healing to Wellness Court program unless the following certification has been completed. I hereby certify that I have fully explained to my client the Family Healing to Wellness Court program, and I have reviewed with my client the contents of the Family Healing to Wellness Court Participant Handbook and the Conditions of Participation form (MLBF-WC-215).

Parent/Guardian's Legal Counsel's Signature

Date

Parent/Guardian's Legal Counsel's Printed Name

By signing this, I acknowledge and agree to follow everything in the Family Healing to Wellness Court Participant Handbook. If I have any questions, I will contact my attorney.

Applicant's Signature

Date

Applicant's Printed Name