SUPERIOR COURT OF CALIFORNIA

COUNTY OF SANTA CRUZ
COLLABORATIVE COURTS OFFICE
701 OCEAN STREET
SANTA CRUZ, CA 95060
(831) 420-2498
www.santacruzcourt.org

INSTRUCTIONS FOR VETERAN'S TREATMENT PROGRAM (VTP)

FOR THE VETERAN: If you have ever served in the United States Military (Army, Air Force, Coast Guard, Navy or Marines) you may be eligible for alternative sentencing programs and additional treatment at no cost to you. It does not matter how long you served, whether you served in combat, or what your discharge characterization was. If you are interested in participating, you must fill out the attached forms and submit them. You should discuss your participation with your defense attorney, if you have one. Once completed, please forward this packet of information to Travis Deyoung at Travis.Deyoung@santacruzcounty.us. **You must complete all four forms – this one, the ML-100 the VA form 10-5345, and the SF-180 if you wish to be considered for the program.**

1. Name: _____ Last 4 digits of SSN: _____

Phone number: _____ Email: _____ In custody? ☐yes ☐ no

Address: _____

City: _____ State: _____ Zip code _____

2. What branch of the military did you serve in? _____

3. What year(s) did you serve? _____

4. What was your discharge characterization? (check one)

Honorable ☐ General ☐ Other than Honorable ☐ Bad Conduct ☐ Dishonorable ☐

5. Did you serve in a combat theater? ☐ yes ☐ no) If so, list dates and locations.

_____

6. Were you wounded or decorated for combat actions? ☐ yes ☐ no) (Note: Wounds or decorations are not required, but may be a factor weighing in your favor.) If so, list dates and decorations received: _____

_____

7. Do you suffer from any of the following: post-traumatic stress disorder, traumatic brain injury, sexual trauma, substance abuse or mental health issues ***as a result of your military service?*** If so, list the applicable conditions.

_____

8. Have you received treatment for Substance Use Disorder or other mental conditions? _____

9. Are you receiving Veteran's Administration services? ☐ yes ☐ no) If so: _____

VA Healthcare ☐ yes ☐ no). Last treatment location: _____

Vet-Center ☐ yes ☐ no). Last treatment location: _____

VA Monetary Benefits ☐ yes ☐ no). Amount $ _____ Reason for benefit: _____

10. Other Health Insurance? _____

11. Are you represented by defense counsel? ☐ yes ☐ no) If so, by whom?

Name: _____ Phone number: _____

12. I understand that information concerning my military service and medical issues as they relate to my military service will be shared with the Veteran's Services Officer, the District Attorney's Office, the Veteran Advocate and the court if I choose to participate in this program.

_____ _____

Participant Signature Date