PANHANDLE REGIONAL PROBLEM SOLVING COURT (PRPSC)
POTTER COUNTY COURT AT LAW #2-THE HONORABLE JUDGE MATTHEW HAND
500 S. FILLMORE RM 402, AMARILLO, TEXAS 79101 PHONE: 806-379-2380 FAX: 806-379-2222

PRPSC APPLICATION (Updated 2025)

I. Information

Defendant's Name: _____

Defense Counsel Name: _____

Cause Number(s): _____

Case(s) assigned to: ☐ 108th District Court ☐ 251st District Court ☐ 47th District Court ☐ 320th District Court ☐ 181st District Court ☐ County Court At Law #1 ☐ County Court At Law #2

Type of Case:

- ☐ Possession of a Controlled Substance
- ☐ Driving While Intoxicated – 3rd or more
- ☐ Evading Arrest in Vehicle
- ☐ Theft – 2 or more prior convictions
- ☐ Criminal Mischief
- ☐ Burglary of Building
- ☐ Felony Assault
- ☐ Misdemeanor
- ☐ Other: _____

I have been diagnosed with bipolar, schizoaffective disorder, schizophrenia, major depressive disorder, or post traumatic stress disorder (PTSD). I am a defendant whose participation in a specialty court, considering the circumstances of my conduct, personal and social background, and criminal history, is likely to achieve the objective of ensuring public safety through rehabilitation. I am not using my diagnosis as an excuse for my criminal conduct. I am instead seeking treatment for the problems, so that I am able to avoid criminal conduct from this point forward.

I understand that application is no guarantee of acceptance into the PRPSC. The prosecuting agency will conduct a review of my criminal history and the current offense for approval. Violent or assaultive offense (Aggravated Assault, Assault Family Violence, Injury to a Child/Elderly, etc.) may be approved on a case by case basis. Other offenses may be ineligible as well depending on the facts involved or the applicant's criminal history.

By submitting this application to the PRPSC for consideration, I agree to abide by all conditions of bond (if I am granted a bond), I agree to submit to a complete evaluation as directed by the PRPSC, and I agree to provide any requested financial or other documentation as requested by the PRPSC. I understand that failure to abide by conditions of bond, failure to submit to evaluation and treatment during the application process, or failure to submit requested financial or other documentation as requested may result in my application to the PRPSC being denied and my case/s proceeding through the regular criminal justice system.

It is my responsibility to work with my attorney and the PRPSC in a timely manner to provide any necessary documentation and to update any of my contact information if it changes while my application is pending. While my application is pending, I am still responsible to make any court appearances, contact my bond company, and to contact my attorney. I understand that failure to uphold these responsibilities may result in my application to the PRPSC being denied and my case/s proceeding through the regular criminal justice system.

II. Personal Data

(Please Print)

Personal Information

First Name	*Middle Name*	*Last Name*	*Maiden Name*
Nickname	*Alias*	*Place of Birth*	*Date of Birth*
Race	*Citizenship*	*Marital Status*	*Number of Dependents*
Social Security Number	*Driver's License Number or State ID*	*State Issuing Driver's License*	*Expiration Date*
Highest Education Completed			

Physical Address

Street Address	*City, State, Zip*	*County*
How long have you lived at this address?		

Mailing Address

Address	*City, State, Zip*	*County*

Applicant's Contact Information

Home Phone	*Cell Phone*	*Email Address (required)*

Employment

Employment Status (check one):

☐ Full-time ☐ Part-time ☐ Not employed ☐ Seasonal
☐ Student ☐ Retired ☐ Disabled ☐ Homemaker

Employer	*Position or Title*	
Address	*City, State, Zip*	*Work Phone*
Supervisor's Name	*How long have you worked here?*	

If Applicant is a Student:

name of the school/college you are attending? _____

Unemployed:

How long have you been unemployed? _____

When were you last employed? _____

III. Prior Contacts with the Criminal Justice System

Prior contacts with the criminal justice system, regardless of disposition, include, but are not limited to, Juvenile Records, Adult Arrests or Citations, Out-of-State Arrests or Citations, offenses for Minor in Possession of Alcohol, Minor in Consumption of Alcohol, Public Intoxication, Class C Assault, and Possession of Drug Paraphernalia. Applications must be supplemented when contact with the Criminal Justice System occurs after applications are filed. This section does not include traffic citations.

Date of Arrest or Citation	*Place of Arrest or Citation*	*Offense*	*Disposition*

IV. Substance Abuse History

Are you currently on any prescription medications? ☐ Yes ☐ No

If yes, please list those medications: _____

_____

Are you currently or have you ever been through a substance abuse program? ☐ Yes ☐ No

If yes, when? _____

If yes, where? _____

Type of Program: ☐ Inpatient ☐ Outpatient

Are you currently or have you ever been in an AA/NA Support Group? ☐ Yes ☐ No

V. Mental Health Background

Have you been diagnosed with (circle one) BiPolar Disorder Schizophrenia Schizoaffective Disorder Major Depression Post Traumatic Stress Disorder

If so, who/where was diagnosis made:_____

How old were you when you were diagnosed?_____

Were you in special education classes when in school? _____

Have you ever been committed to a mental institution? If so, please provide the facility name and dates of in-patient stay.

_____

Do you currently have a mental health case manager through TPC or another mental health provider? If so, please provide your case manager's name and contact information, as well as the date you last met with him/her.

_____

_____

VI. Medical History

Are you currently under a doctor's care? (if yes, please list all of your current physicians if more than one:) _____

Name of Doctor: _____

Name, Address, and Phone Number of the Clinic or Doctor's office:_____

_____

For what is the current physician treating you? _____

Are you currently seeing a counselor? (if yes, please list all of your current counselors if more than one:) _____

Name of counselor: _____

Name, Address, and Phone Number of the Clinic or Counselor's office: _____

_____

_____

If you are currently receiving medical care, counseling, and/or medication, how are you paying for those services?

___Private Insurance ___Medicaid/Medicare ___Cash ___Uncertain

___Other: (please describe) _____

_____

VII. Emergency Contact Information

Provide the name, your relationship, number, and email of at least 2 people you approve for the PRPSC to contact about you.

_____

_____

_____

VIII. Acknowledgement by Defendant and Certification of Information

I have been advised by my Attorney or the Court that I may be eligible for participation in the Panhandle Regional Problem Solving Court. I have also been fully advised of the details of the PRPSC. Further, I have been fully advised by my Attorney or the Court of my constitutional rights as a criminal defendant and that the same will be set forth in writing and explained to me before I make any agreement to participate in the PRPSC. I will be required to waive said constitutional rights.

I understand that I must abide by all terms and conditions of the PRPSC as explained to me by the PRPSC and my attorney. This may include fees, restitution, or other financial costs if so ordered by the PRPSC or the trial court. I understand that all payments I am ordered to make shall be made by cashier's check or money order.

I hereby apply for status as a participant in the PRPSC and request that the Prosecuting Attorney's Office temporarily abate proceedings in order to permit consideration of this application. I understand that the decision to commence criminal proceedings or to divert from traditional prosecution in my case rests with the Prosecuting Attorney's Office as well as the PRPSC and the Presiding Judge, and that my application is not an automatic acceptance into the program.

I authorize the PRPSC to conduct an investigation to determine my suitability for this program. I understand the investigation may include interviews of individuals deemed necessary by the PRPSC. I authorize the PRPSC to conduct such interviews and review records concerning me in the possession of others in a reasonable manner.

I understand that a false answer to any question during this interview may be grounds for a recommendation against placement into this PRPSC or removal (after placement into the PRPSC), in which case the prosecuting agency will resume prosecution on the original charges.

I understand that if I am accepted into the PRPSC, failure to successfully complete the PRPSC or my voluntary withdrawal from the PRPSC may be used against me on the issue of guilt or innocence or punishment in any future prosecution for this offense. However, if I am not accepted into the PRPSC, neither this Agreement nor any other documents filed with the District Attorney's Office AND/OR County Attorney's Office as a result of my application with the PRPSC, can be used against me.

I understand and agree to abide by any treatment recommendations ordered by the PRPSC, my current medical provider, or CSCD. I understand I will be interviewed by a member of the PRPSC and will be given an assessment without my attorney present. My attorney and I consent to this interview and assessment. If I am accepted into the PRPSC, I understand and swear to keep all information confidential that is discussed in PRPSC about myself and other participants.

I swear and certify the information contained in this application is true and correct and I did not withhold any information. I understand that failure to complete the application honestly and correctly or to withhold any information shall be grounds for denial into or removal from the program.

_____ _____

Defendant's Signature *Date*

_____

Defendant's Name (printed)

_____

_____, *Defense Counsel*

PANHANDLE REGIONAL PROBLEM SOLVING COURT

INFORMED CONSENT FOR INTERVIEW AND PERMISSION TO RELEASE INFORMATION

I, the undersigned, understand that I am being interviewed by a member of the Panhandle Regional Problem Solving Court team, to help determine if I preliminarily meet the criteria for admission into the PRPSC. I understand that this interview does not mean I am or will be accepted into the program and as such, I am required to follow all current bond, pretrial, or court ordered conditions.

I hereby consent to the interview and TRAS as described above and give my permission for information gathered during this interview, and other sources to be shared with the members of the PRPSC team, which includes but is not limited to: other mental health professionals for consultation and training purposes, mentor coordinators, criminal defense attorneys, prosecutors and other criminal justice/court staff and personnel. By signing this document, I understand I am waiving by legal rights to confidentiality to allow judicial efficiency due to my current pending case(s).

I agree to meet with my attorney and discuss the conditions of the program to ensure I am making an informed decision to enter the program before I sign any required legal documents. I understand that admission to this program is voluntary and that the final approval for admission, will be determined by a representative of the Prosecuting Attorney's Office and the Judges of the Court.

Printed Name: _____

Applicant Signature: _____

Defense Counsel Signature: _____

Date: _____

FERPA CONSENT TO RELEASE STUDENT INFORMATION

TO: _____
(Name of School Official and Department that will be releasing the educational records)

Please provide information from the educational records of _____ to:
the Panhandle Regional Problem Solving Court and my attorney

(Note: this Consent does not cover medical records held solely by Student Health Services or the Counseling Center – contact those offices for consent forms.)

The only type of information that is to be released under this consent is:
_____ transcript
_____ disciplinary records
_____ recommendations for employment or admission to other schools
X____ all records
_____ other (specify) _____

The information is to be released for the following purpose:
____ family communications about university experience
____ employment
____ admission to an educational institution
X___ other (specify) Legal Proceedings and Treatment

I understand the information may be released orally or in the form of copies of written records, as preferred by the requester. I have a right to inspect any written records released pursuant to this Consent (except for parents' financial records and certain letters of recommendation for which the student waived inspection rights). I understand I may revoke this Consent upon providing written notice to [Name of Person listed above as the School Official permitted to release the educational records]. I further understand that until this revocation is made, this consent shall remain in effect and my educational records will continue to be provided to [Name of Person listed above to whom the educational records will be released] for the specific purpose described above.

Name (print)_____ Signature_____

Student ID Number or date of birth_____ Date_____

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

NAME OF PATIENT OR INDIVIDUAL

_____
Last First Middle

OTHER NAME(S) USED _____

DATE OF BIRTH Month _____ Day _____ Year _____

ADDRESS _____

_____

CITY _____ **STATE** _____ **ZIP** _____

PHONE (____) _____ **ALT. PHONE** (____) _____

EMAIL ADDRESS (Optional): _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (____) _____ Fax (____) _____

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name **Panhandle Regional Problem Solving Court**
Address **500 S. Fillmore, County Court at Law #2**
City **Amarillo** State **TX** Zip Code **79110**
Phone (**806**) **349-4875** Fax (____) _____

REASON FOR DISCLOSURE
(Choose only one option below)

- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Billing or Claims
- ☐ Insurance
- ☒ Legal Purposes
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ Other _____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- ☐ All health information
- ☐ Physician's Orders
- ☐ Progress Notes
- ☐ Pathology Reports
- ☐ History/Physical Exam
- ☐ Patient Allergies
- ☐ Discharge Summary
- ☐ Billing Information
- ☐ Past/Present Medications
- ☐ Operation Reports
- ☐ Diagnostic Test Reports
- ☐ Radiology Reports & Images
- ☐ Lab Results
- ☐ Consultation Reports
- ☐ EKG/Cardiology Reports
- ☒ Other: Mental Health/ Substance Abuse

Your initials are required to release the following information:

× _____ Mental Health Records (excluding psychotherapy notes)
× _____ Drug, Alcohol, or Substance Abuse Records
_____ Genetic Information (including Genetic Test Results)
_____ HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X _____ _____
Signature of Individual or Individual's Legally Authorized Representative **DATE**

Printed Name of Legally Authorized Representative (if applicable): _____
If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian ☐ Other _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURE X _____ _____
Signature of Minor Individual **DATE**

IMPORTANT INFORMATION AbOUT THE AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

The Attorney General of Texas has adopted a standard Authorization to Disclose Protected Health Information in accordance with Texas Health & Safety Code § 181.154(d). This form is intended for use in complying with the requirements of the Health Insurance Portability and Accountability Act and Privacy Standards (HIPAA) and the Texas Medical Privacy Act (Texas Health & Safety Code, Chapter 181). **Covered Entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.**

Covered entities, as that term is defined by HIPAA and Texas Health & Safety Code § 181.001, must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. (Tex. Health & Safety Code §§ 181.154(b),(c), § 241.153; 45 C.F.R. §§ 164.502(a)(1); 164.506, and 164.508).

The authorization provided by use of the form means that the organization, entity or person authorized can disclose, communicate, or send the named individual's protected health information to the organization, entity or person identified on the form, including through the use of any electronic means.

Definitions - In the form, the terms "treatment," "healthcare operations," "psychotherapy notes," and "protected health information" are as defined in HIPAA (45 CFR 164.501). "Legally authorized representative" as used in the form includes any person authorized to act on behalf of another individual. (Tex. Occ. Code § 151.002(6); Tex. Health & Safety Code §§ 166.164, 241.151; and Tex. Probate Code § 3(aa)).

Health Information to be Released - If "All Health Information" is selected for release, health information includes, but is not limited to, all records and other information regarding health history, treatment, hospitalization, tests, and outpatient care, and also educational records that may contain health information. As indicated on the form, specific authorization is required for the release of information about certain sensitive conditions, including:

- Mental health records (excluding "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501).
- Drug, alcohol, or substance abuse records.
- Records or tests relating to HIV/AIDS.
- Genetic (inherited) diseases or tests (except as may be prohibited by 45 C.F.R. § 164.502).

Note on Release of Health Records - This form is not required for the permissible disclosure of an individual's protected health information to the individual or the individual's legally authorized representative. (45 C.F.R. §§ 164.502(a)(1)(i), 164.524; Tex. Health & Safety Code § 181.102). If requesting a copy of the individual's health records with this form, state and federal law allows such access, unless such access is determined by the physician or mental health provider to be harmful to the individual's physical, mental or emotional health. (Tex. Health & Safety Code §§ 181.102, 611.0045(b); Tex. Occ. Code § 159.006(a); 45 C.F.R. § 164.502(a)(1)). If a healthcare provider is specified in the "Who Can Receive and Use The Health Information" section of this form, then permission to receive protected health information also includes physicians, other health care providers (such as nurses and medical staff) who are involved in the individual's medical care at that entity's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purposes permitted by law for that specified covered entity or person. If a covered entity other than a healthcare provider is specified, then permission to receive protected health information also includes that organization's staff or agents and subcontractors who carry out activities and purposes permitted by this form for that organization. Individuals may be entitled to restrict certain disclosures of protected health information related to services paid for in full by the individual (45 C.F.R. § 164.522(a)(1)(vi)).

Authorizations for Sale or Marketing Purposes - If this authorization is being made for sale or marketing purposes and the covered entity will receive direct or indirect remuneration from a third party in connection with the use or disclosure of the individual's information for marketing, the authorization must clearly indicate to the individual that such remuneration is involved. (Tex. Health & Safety Code §181.152, .153; 45 C.F.R. § 164.508(a)(3), (4)).

Limitations of this form - This authorization form shall not be used for the disclosure of any health information as it relates to: (1) health benefits plan enrollment and/or related enrollment determinations (45 C.F.R. § 164.508(b)(4)(ii), .508(c)(2)(ii); (2) psychotherapy notes (45 C.F.R. § 164.508(b)(3)(ii); or for research purposes (45 C.F.R. § 164.508(b)(3)(i)). **Use of this form does not exempt any entity from compliance with applicable federal or state laws or regulations regarding access, use or disclosure of health information or other sensitive personal information (e.g., 42 CFR Part 2, restricting use of information pertaining to drug/alcohol abuse and treatment), and does not entitle an entity or its employees, agents or assigns to any limitation of liability for acts or omissions in connection with the access, use, or disclosure of health information obtained through use of the form.**

Charges - Some covered entities may charge a retrieval/processing fee and for copies of medical records. (Tex. Health & Safety Code § 241.154).

Right to Receive Copy - The individual and/or the individual's legally authorized representative has a right to receive a copy of this authorization.