ADULT RECOVERY COURT
ELIGIBILITY DETERMINATION

Court Address
212 E. Paw Paw Street – Suite LL001, Paw Paw, MI 49079

Court Telephone No.
(269) 657-8200

1. REFERRAL SOURCE – Complete this first section ONLY and send to Specialty Courts Administrator.

Date of Referral	Defendant's First Name Middle Name Last Name		
Defendant's Date of Birth	County of Residence	Phone Number	
Address	City	State	Zip
Current Charges			
Referral Completed by	Relationship to Defendant	Phone Number	

Date

Referring Party's Signature

2. LEGAL SCREEN – To be completed by Specialty Courts Administrator or MDOC.

Case Number	Defense Attorney	
Court ☐ District ☐ Circuit	Next Court Date	Candidate is ☐ Incarcerated ☐ On bond
Charge Leading to Recovery Court referral		
Describe any other pending charge(s)		

Offense History:

Is the defendant currently charged with or currently convicted of **criminal sexual conduct**, in any degree?
☐ **Yes** ☐ **No**

Is the defendant currently charged with or currently convicted of a **violent crime resulting in death or serious bodily harm?** ☐ **Yes** ☐ **No**

If "Yes" is answered in either of the above questions, the defendant is **NOT** eligible for Recovery Court.

Notes:

☐ Legally Eligible - unless the guidelines are determined to be presumptive prison

☐ Legally Ineligible

Date

Specialty Court / MDOC Signature

3. CLINICAL LIAISON – Complete this section

Client name and address:	DOB:	Age:	Date of Clinical Screen:
	Phone 1:	Phone 2:	
Clinical Diagnosis w/ Code:			
Severity of Illness:			
Level of Functional Impairment:			
Able to give informed consent? ☐ Yes ☐ No			
Motivated to change? ☐ Yes ☐ No			
Willing to participate in a 12-24 month intensive program consisting of treatment, case management, drug testing, and court appearances? ☐ Yes ☐ No			
Clinically Eligible for Recovery Court? ☐ Yes ☐ No			
If clinically eligible, is Recovery Court recommended? ☐ Yes ☐ No Please describe:			
If not clinically eligible, what services or other programming is recommended:			
Additional Notes:			

Clinical Liaison Printed Name

Date

Signature

Clinical Liaison: Please return the completed form to the Specialty Court Administrator.