

**YORK COUNTY COURT OF COMMON PLEAS  
HERION/OPIOID WELLNESS PROGRAM REFERRAL FORM**

DEFENDANT: \_\_\_\_\_ OTN/CR#: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

DOB: \_\_\_\_\_ SS#: \_\_\_\_\_ TELEPHONE #: \_\_\_\_\_

RACE: \_\_\_\_\_ SEX: M / F

CHARGES: \_\_\_\_\_ BAIL/YCP: (circle one)

ARE YOU IN NEED OF INTERPRETER SERVICES: Y/N IF YES PLEASE SPECIFY LANGUAGE \_\_\_\_\_

VETERAN: Y / N HAVE YOU SERVED ACTIVE COMBAT: Y / N ARE YOU A PURPLE HEART RECIPIENT: Y / N

DO YOU HAVE THE FOLLOWING?

HIGH SCHOOL DIPLOMA Y/N GED Y/N BIRTH CERTIFICATE Y/N PHOTO IDENTIFICATION Y/N

Presumptive Qualifying Characteristics.

\_\_\_\_\_ An individual charged with any criminal offense when it appears the offense is motivated by a desire to support a drug habit. Attorney must indicate client's drug of choice.

Please process the "Referral Form" as follows:

1. Check all items above that apply to the applicant.
2. Attach copies of all pending criminal complaints and probable cause affidavits to the Referral Form.
3. Referral must be filed within 30 days of arraignment.
4. A time stamped copy needs to be given to the Clerk of Courts and York County Adult Probation at 45 N. George St. York, PA 17401.
5. Any questions please call the Treatment Court Administrator at 717-771-9602.

Preparer's Name & Title: \_\_\_\_\_ Date: \_\_\_\_\_

**SUPPORTING INFORMATION:** Use the attached form to document any evidence and/or facts that will support your client being accepted into the HOW-C program.

**RESTITUTION:** \$ \_\_\_\_\_

**FOR COURT USE ONLY:**

\_\_\_\_\_ Eligible \_\_\_\_\_ Ineligible due to: \_\_\_\_\_

\_\_\_\_\_ Eligible outside guidelines due to: \_\_\_\_\_

**(FORWARD TO TREATMENT COURT ADMINISTRATION)**

**SUPPORTING EVIDENCE FOR ACCEPTING CLIENT:**