



Referral To Seattle Municipal Court Veterans Treatment Court (VTC)

SEND REFERRAL & DOCUMENTATION TO:

Scott Swaim, VTC COURT LIAISON

Email: scottswaim@milspecvets.com

Phone: 206-909-4745

DATE: _____

Defense Attorney: _____ Phone #: _____

Defense Attorney Email: _____

Defendant's Full Name: _____ DOB: _____

SSN #: _____ B/A #: _____

Defendant's Address: _____

Defendant's Phone #: _____

Marital Status: _____ Children (Circle): (Y) / (N) Residing with you (Circle): (Y) / (N)

Housing Needed (Circle): (Y) / (N) Net Income: _____

Other Source of Income (Circle): SSI/SSDI/SSA VA MCS/ABD Retirement

Case Manager: _____ Phone #: _____

SMC Case #: _____ Charges: _____

Next scheduled hearing date, time, & location: _____ Hrg Type: _____

Other open SMC Cases: _____

Cases in Other Jurisdictions: _____

Custody Status: IN OUT

Been convicted of a "Class A" felony or Strike Crime (circle): (Y) / (N)

If yes, what crime: _____

Branch of Service: _____ Years in Military Service: _____ Deployed To Combat Theater (Circle): (Y) / (N)

Utilized VA Services Before (Circle): (Y) / (N) If yes, what VA facility: _____

Character of discharge (Circle): Honorable / General / Other Than Honorable (OTH) / Bad Conduct Discharge (BCD) / Dishonorable Discharge (DD)

Note: Typically the attorney requesting the case be transferred to VTC completes this Referral Request. When completed, this Referral Request along with a signed Release of Information is emailed or faxed to the Court Liaison who reviews it & makes a recommendation to the VTC Judge. To facilitate this process please contact the Court Liaison by phone or email with any questions you have about your referral. The court liaison will inform you whether your case has been accepted into VTC for a look-see hearing.

**** Please provide this completed referral and the following information: (attach additional sheets as needed)**

- SIGNED VTC Release of Information AND VA Release of Information
- A copy of the Incident Report
- A copy of Defendant's Criminal History
- Prosecutor's Sentence Recommendation _____
- Previous MH assessment/treatment (circle): (Yes) / (No) _____
- If yes, Provider name: _____ Established Axis 1 diagnosis: _____
- Contact names and phone numbers for other information (relatives, doctors, etc.) _____
- Brief explanation as to reason for referral _____