



County (ies) and Docket number(s) of criminal judgements relevant to referral to WRRC:

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Date of last arrest: \_\_\_\_\_ (MM/DD/YYYY)

Other than these charges and sentences identified above, are there any other pending criminal charges or warrants against you (including: probation or community corrections violations) in any jurisdiction? Yes

No

**Description of Women’s Residential Recovery Court Program:**

The WRRC is a court-supervised residential recovery court program for non-violent justice involved females who are actively participating in a local recovery court, have a greater need for intensive substance abuse and/or co-occurring treatment services and supervision, and have not been successful in recovery court programming in their community. The primary purpose of the program is to provide court-supervised long-term residential services to individuals diagnosed with a substance use and/or co-occurring disorder.

The WRRC Program is part of the recovery court system overseen by the Tennessee Department of Mental Health and Substance Abuse Services. The program is operated by the Nashville Drug Court Support Foundation (DBA – Doing Business As) the Nashville Recovery Court Support Foundation. WRRC is presided over by Judge Angelita Blackshear Dalton, a Criminal Court Judge from the 20<sup>th</sup> Judicial District. Retired Judge Seth W. Norman also serves in a consulting role.

The WRRC is post-plea. Applicants are screened based on legal eligibility, criminal background, severity of addiction, medical, and other conditions. The duration of the application process will depend on various factors including the number of applicants, number of available beds, the background check, and completion of all required documents. When an applicant has been accepted, the referring recovery court must enter an appropriate order to transfer jurisdiction to the WRRC Presiding Judge. A copy of that order must be sent to WRRC.

The WRRC Presiding Judge assumes jurisdiction over each participant while in the WRRC Program. Participants receive treatment, as indicated through clinical assessment, for no more than 12 months. Referring recovery courts will receive monthly updates on each participant while in the program. The WRRC Presiding Judge will make final decisions regarding graduation from the WRRC Program. Prior to graduating from the WRRC, the WRRC staff will participate with the referring recovery court in formulating a transition plan. When a resident successfully graduates from the WRRC Program, she is transferred back to her referring recovery court for the remainder of her sentence according to the terms and conditions of her referring recovery court.

## **Eligibility Criteria for Admission to WRRC:**

To be eligible for admission to the WRRC, the applicant must satisfy the following criteria:

1. The applicant must be a current participant in a certified recovery court program under T.C.A. Section 16-22-1041 et. seq. This means, among other things, that the applicant cannot be a violent offender or sex offender.
2. The applicant must not have any escape charges in their criminal history nor have more than two absconding violations of probation in their criminal history.
3. The applicant must be recommended to WRRC by her referring recovery court.
4. Participation in the program is voluntary. The applicant must affirmatively express an interest in the WRRC Program and agree to follow all WRRC rules and policies.
5. The applicant must be a felony offender subject to one or more criminal judgements with sentences of three years or more.
6. The applicant must be eligible for probation under T.C.A. Section 40-35-303 or community corrections under T.C.A. Section 40-36-106.
7. The applicant must not have any pending or unresolved criminal charges in any jurisdictions including jurisdictions outside of Tennessee.
8. The applicant must be assessed for a substance use disorder, and it must be determined that she meets the criteria for a substance use disorder.
9. The applicant's TNRAS summary score must be in the High to Extremely High Range.
10. The applicant must not be diagnosed with any significant medical or psychiatric problems that the WRRC, according to the WRRC's determination, is not equipped to handle.
11. The applicant must be approved for participation in the WRRC program by the WRRC Executive Director and WRRC Presiding Judge.

## **Application Process and Required Materials for Admission to WRRC:**

The following application materials must be furnished by the referring recovery court and should be submitted to WRRC Executive Director via email: [michelle@wrrctn.com](mailto:michelle@wrrctn.com)

1. This application form filled out and signed by the applicant and a representative of the referring recovery court.
2. Medical history filled out and signed by the applicant. The applicant must include any current medications and the date and dosage of medications last taken by the applicant.
3. Summary of applicant's criminal background.
4. Copies of the applicant's underlying criminal judgements related to the referral to the WRRC.
5. Completed TN-RAS.
6. Completed Addiction Severity Index.
7. If the applicant is a military veteran, the applicants DD Form 214, certificate of release or discharge from active-duty information must also be included, if available.

**NOTE: Ensure all signatures are completed or the application will not be accepted.**

## **Participation in the WRRC Program:**

WRRC utilizes evidence-based treatment practices. The program is operated as a modified therapeutic community combined with gender specific and trauma specific treatment with a foundation of the 12 steps of recovery. It is important that all residents make progress in their recovery and participate in the community in a positive way.

In its discretion, the WRRC may discharge any resident from the program for a variety of reasons, including, but not limited to the following:

1. The resident is diagnosed with a medical, psychiatric, or psychological condition that the WRRC is not equipped to handle.
2. The resident is unwilling or unable to fully participate in the WRRC program, including the clinical activities and community service.
3. In the clinical judgement of the WRRC treatment team, the resident is not making satisfactory progress in her treatment or recovery program or is not open to treatment at WRRC.
4. In the clinical judgement of the WRRC treatment team, the resident is a negative influence in the WRRC community which potentially undermines treatment or recovery of other residents.
5. The resident commits a serious violation of rules and is deemed inappropriate for this program.
6. If for any reason a resident is terminated from the WRRC program, her case will be transferred back to her referring court for further disposition.

## **Applicants Agreement: (signature required below)**

### Agreement to be bound by WRRC Rules and Policies:

I understand and agree that if I am admitted to the WRRC, I will obey all WRRC rules and policies. I understand that my failure to follow said rules and policies can bring about sanctions, including incarceration and/or my immediate expulsion from the program.

### Agreement to live at the WRRC facility:

If I am admitted to the WRRC, I agree to live at the WRRC facility as recommended by the WRRC treatment team.

### Acknowledgement of Limited Medical Care:

I understand and acknowledge that the WRRC is equipped to handle only basic medical and psychiatric needs and costs for such services, are limited to the following: (1) on-site part-time nursing; (2) on-site part-time psychiatric nurse practitioner; (3) recovery-safe medications prescribed by WRRC medical providers; and (4) limited dental care.

I understand that I will be held financially responsible for any medical and dental care (including ambulance and emergency room treatment) that WRRC is not equipped to handle or that is beyond the scope of the practices provided by on-site nursing.

### Communication:

I understand that communication with anyone outside of the WRRC campus is a privilege.

The following is an outline of the community policy:

1. Mail: Incoming and outgoing mail is subject to being searched.
2. Phone: On the day of your intake at the WRRC, you will be allowed an initial phone call. After the initial phone call, unless an emergency arises, residents are not allowed to communicate with anyone outside of the WRRC facility by phone for at least the first 30 days. After 30 days when telephone calls are permitted, they are usually limited to 1 call weekly. Additional calls may be permitted as an incentive for progress in the program.
3. Family visits: After a minimum time in the program, as an incentive for progress in the program, WRRC residents will be allowed family visits.
  - Visitation is determined by recommendation of the counselor, and a request is made by the counselor to the WRRC Presiding Judge for approval.
  - Frequency of visitation and logistics of visitation are coordinated by the counselor with the resident.
  - Visits may be facilitated in person or remotely.
4. Passes: Residents will not be allowed passes away from the WRRC campus except in some cases for specific recovery-related purposes as they prepare to transition out of the WRRC. This is handled in coordination with their referring recovery court.

**NOTE:** Phone calls, family visits, and passes are not guaranteed. Phone calls are approved by staff. Family visits and passes must be approved by the WRRC Presiding Judge.

Acknowledgement of Personal Property:

I understand that I will be limited to the personal property that I may have at the WRRC. I understand that the WRRC will not be responsible for any lost or missing personal property.

Acknowledgement of Searches and Seizures:

I understand, and hereby give my consent, that while I am at the WRRC, my belongings and my personal area may be searched by staff at any time without notice. I also understand and agree that any prohibited items, or any other items deemed by staff to be inappropriate that are in my possession, may be confiscated by WRRC staff.

Acknowledgement of Drug Testing:

I understand and agree that while I am at the WRRC, I may be drug tested at any time without notice. I also understand and agree that a positive drug test may result in sanctions or termination from the program.

Acknowledgement of Absconding:

I understand that if I ever leave the WRRC campus unaccompanied by a WRRC staff member without a proper written authorization, I may be prosecuted for felony escape pursuant to T.C.A. Section 39-16-605(a), (c)(1)(B), in addition to violation of probation or community corrections. There will be no exceptions to this rule.

Acknowledge of Agreement Regarding My Behavior:

I understand that I must accept and abide by the directives of the WRRC staff and to follow all WRRC's rules and policies. I also understand that I must make full and truthful reports to any staff member upon request, and I must not possess or use alcohol, drugs, tobacco/nicotine products, or possess any prohibited items (**See Prohibited Items Addendum**). I also understand and agree to not engage in any physical altercation or verbal abuse with any member of the WRRC community – this includes all staff members and all residents. I understand and agree to actively engage in my recovery program and in community service work under staff supervision, and to treat all members of the WRRC community (staff and residents) with respect.

Possible Consequences for Violating this Agreement or the WRRC Rules:

I fully understand that I am transferring the supervision of my sentence to the Presiding Judge overseeing the WRRC. Should I violate any of the terms and conditions of this agreement or the WRRC rules and policies, I understand that I may be subject to:

1. The imposition of a jail sanction of up to twenty-one (21) days without a hearing;
2. Referral back to the jurisdiction of my referring recovery court, and that Judge shall have the right to rule upon said violation and impose any sentence that is deemed appropriate; and/or
3. Termination from the WRRC program.

I understand that if I am terminated from the WRRC, for any reason, if I am on furlough, my furlough could be terminated, and I could be returned to the appropriate penal institution without the benefit of a hearing. I understand if I am on community corrections, after a hearing, my community corrections could be revoked, and the court could enhance my sentence. Finally, I understand if I am on probation, after my hearing, my probation could be revoked.

**Signature Page:**

**In the space given below, please briefly write the reason why you want to be admitted to Women's Residential Recovery Court:**

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Have you read this entire form, and do you understand it? **(Write yes or no)**

Have you had the opportunity to discuss this application form and the WRRC program with your attorney and with your referring recovery court? **(Write yes or no)**

**Referring Recovery Court (this must be completed):**

WRRC Applicant Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Referring Recovery Court (this must be completed):**

By (staff name): \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

**NOTE: IT IS THE RESPONSIBILITY OF THE REFERRING COURT TO ARRANGE TRANSPORTATION FOR THE PARTICIPANT TO THE WRRC FACILITY AND FROM THE WRRC FACILITY TO THEIR HOME COMMUNITY UPON COMPLETION OF THE PROGRAM OR EXPULSION OF THE WRRC PROGRAM.**

I, \_\_\_\_\_ (print your name), agree to the following:

- 1. I have read and I fully understand all provisions of this application form.**
- 2. I have had the opportunity to review this application form with my attorney and ask questions in an open court.**
- 3. I have read and I fully understand all agreements listed above.**
- 4. I understand the possible consequences for violating this agreement or the WRRC rules.**

**Applicant Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## **Provisions for Referring Recovery Court:**

Recommendations for Admission to the WRRC: By signing this application form, the applicant's referring recovery court is recommending the applicant's admission to the WRRC.

Certification of Applicants Eligibility: By signing this application form, the applicant's referring recovery court is certifying it has conducted a NCIC background check on the applicant, and that to the best of the recovery court's knowledge, the applicant satisfies all eligibility requirements for participating in the WRRC program as set forth in the above eligibility section.

Transportation: When a resident is admitted to WRRC, she is to be transported to the WRRC on the scheduled court date. The referring recovery court is responsible for transporting the new resident to WRRC as well as from WRRC upon completion of the program or if the resident is terminated from the program. **The street address is 1262 Foster Avenue, Nashville, TN 37210.**

Arrival Time: Unless otherwise authorized by the WRRC Executive Director, the new resident will arrive on the scheduled date and time agreed upon via email between the referring recovery court and WRRC Security Coordinator.

Prescription Medications: If a new resident is taking prescribed medications, she should bring at least a three-week supply, and she should bring any written prescriptions for refills or renewals.

No Luggage: A new resident's personal belongings should be contained in a plastic bag. The WRRC does not have space to store luggage.

No Cash: Residents are not allowed to have cash. Families may send in a gift card or any reloadable Visa available in your area.

Clothing: A resident's term at the WRRC will cover all seasons of the year. However, space for storing clothes is limited. If a resident cannot afford clothing, the WRRC will provide necessary clothing items. **(See Clothing Addendum).**

Hygiene: New residents are encouraged to bring hygiene items that are sealed, unopened and do not contain any alcohol. If a resident cannot afford these items, the WRRC will provide them.

Termination from the Program: If a resident is terminated from the WRRC program, WRRC will promptly notify the referring recovery court. The case will be transferred back to the referring recovery court. The referring recovery court will be responsible for transporting the resident back to that court's jurisdiction. The referring recovery court will have **a maximum of 5 calendar days** to have the resident picked up from the Davidson County Sheriff's Office.

Completion of the Program: When a resident successfully completes the WRRC program, she will be discharged from the WRRC and transferred back to her referring recovery court, which will assume jurisdiction of her case. The resident will then participate in the referring recovery court's program. At least six (6) weeks prior to her anticipated discharge, the WRRC staff will work with the resident and her referring recovery court's staff to prepare an appropriate transition plan.



# Women's Residential Recovery Court

PLEASE FILL OUT ALL FORMS THOROUGHLY

## FEMALE MEDICAL HISTORY FORM

### Applicant Information

Full Name: \_\_\_\_\_  
Last First Middle Initial

Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_

### SOCIAL HISTORY

#### Marital Status

- |                                   |                                  |                                    |
|-----------------------------------|----------------------------------|------------------------------------|
| <input type="checkbox"/> Single   | <input type="checkbox"/> Married | <input type="checkbox"/> Separated |
| <input type="checkbox"/> Divorced | <input type="checkbox"/> Widowed | <input type="checkbox"/> Other     |

#### Tobacco Use

Cigarettes/cigars/pipes:

- |                                  |   |                  |
|----------------------------------|---|------------------|
| <input type="checkbox"/> Never   | <input type="checkbox"/> Used in the past | Quit Date: _____ |
| <input type="checkbox"/> Current | _____ (no.) of packs/day for _____ years  |                  |

Chewing tobacco

- |  |   |                  |
|--|---|------------------|
| <input type="checkbox"/> Never         | <input type="checkbox"/> Used in the past | Quit Date: _____ |
| <input type="checkbox"/> Currently use | _____ (no.) of packs/day for _____ years  |                  |

### PAST MEDICAL HISTORY

**Please select if you have or have had any of the following:**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Environmental Allergies  | <input type="checkbox"/> Depression                       | <input type="checkbox"/> Heart Attack            |
| <input type="checkbox"/> Anemia (low blood)       | <input type="checkbox"/> Diabetes                         | <input type="checkbox"/> Nerve or Muscle Disease |
| <input type="checkbox"/> Anxiety                  | <input type="checkbox"/> Emphysema                        | <input type="checkbox"/> Glaucoma                |
| <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Seizures                         | <input type="checkbox"/> GERD (heartburn/reflux) |
| <input type="checkbox"/> Sickle Cell Anemia       | <input type="checkbox"/> Cancer                           | <input type="checkbox"/> Heart Murmur            |
| <input type="checkbox"/> Stroke                   | <input type="checkbox"/> Cataracts                        | <input type="checkbox"/> HIV/AIDS                |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> High Cholesterol                 | <input type="checkbox"/> Thyroid Disease         |
| <input type="checkbox"/> Clotting Disorder        | <input type="checkbox"/> High Blood Pressure              | <input type="checkbox"/> Tuberculosis            |
| <input type="checkbox"/> COPD                     | <input type="checkbox"/> Kidney disease                   | <input type="checkbox"/> Ulcers                  |
| <input type="checkbox"/> Meningitis               | <input type="checkbox"/> Pregnancy or suspected pregnancy |  |

Other: \_\_\_\_\_

**PAST SURGICAL HISTORY**

Please select if you have or have had any of the following:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Appendectomy                | <input type="checkbox"/> Colon Surgery           | <input type="checkbox"/> Fracture Surgery        |
| <input type="checkbox"/> Brain Surgery               | <input type="checkbox"/> Joint Replacement       | <input type="checkbox"/> Angioplasty/Stent       |
| <input type="checkbox"/> Tonsils/Adenoids            | <input type="checkbox"/> Cardiac Artery Surgery  | <input type="checkbox"/> Ear Surgery             |
| <input type="checkbox"/> Hernia Repair               | <input type="checkbox"/> Pacemaker/defibrillator | <input type="checkbox"/> Small Intestine Surgery |
| <input type="checkbox"/> Valve Surgery (heart valve) | <input type="checkbox"/> Eye Surgery             | <input type="checkbox"/> Spine Surgery           |
| <input type="checkbox"/> Vascular (vein/artery)      | <input type="checkbox"/> Sinus Surgery           | <input type="checkbox"/> Gallbladder Removal     |

Other: \_\_\_\_\_

**FAMILY MEDICAL HISTORY**

**Father:**

Alive:  Yes  No

Father's Age: \_\_\_\_\_ Substance Abuse:  Yes  No

Substance Abuse Issues:  
(If yes, please describe): \_\_\_\_\_

Father's general health is:  Good  Fair  Poor

Reason for father's poor health: \_\_\_\_\_

Cause of death: \_\_\_\_\_

**Mother:**

Alive:  Yes  No

Mother's Age: \_\_\_\_\_ Substance Abuse:  Yes  No

Substance Abuse Issues:  
(If yes, please describe): \_\_\_\_\_

Mother's general health is:  Good  Fair  Poor

Reason for mother's poor health: \_\_\_\_\_

Cause of death: \_\_\_\_\_

**Siblings:**

Number of brothers: \_\_\_\_\_ Health Problems: \_\_\_\_\_

Number of sisters: \_\_\_\_\_ Health Problems: \_\_\_\_\_

<b>FAMILIAL DISEASES</b>
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**Have you or any of your blood relatives had any of the following (include grandparents, aunts and uncles), but exclude cousins, relatives by marriage and half-relatives. Check those to which the answer is yes (leave other blank).**

- |  |  |
|--|--|
| <input type="checkbox"/> Heart attack under age 50 | <input type="checkbox"/> Congenital Heart Disease (existing at birth/not hereditary) |
| <input type="checkbox"/> Strokes under age 50      | <input type="checkbox"/> Heart Surgery   |
| <input type="checkbox"/> High blood pressure       | <input type="checkbox"/> Glaucoma  |
| <input type="checkbox"/> Elevated cholesterol      | <input type="checkbox"/> Obesity (20 or more pounds overweight)                      |
| <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> Leukemia or Cancer under age 60                             |
| <input type="checkbox"/> Asthma or hay fever       |  |

Comments: \_\_\_\_\_

<b>MEDICATIONS</b>
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**Please complete accurately**

	MEDICATION NAME	DOSAGE	FREQUENCY
1.			
2.			
3.			
4.			
5.			
6.			

Comments:

<b>MEDICAL ALLERGIES</b>
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1.
2.
3.
4.
5.
6.

Comments:

## REVIEW OF SYMPTOMS

**REVIEW OF SYMPTOMS:** Select the items in each category that have or have not caused you problems or discomfort.

### **General:**

Recent weight change:  Yes  No  
Fever/chills:  Yes  No  
Night sweats:  Yes  No  
Fatigue:  Yes  No  
Malaise/feeling ill:  Yes  No  
Vascular (vein/artery):  Yes  No

### **Genitourinary:**

Frequent/urgent urination:  Yes  No  
Burning/painful urination:  Yes  No  
Blood in urine:  Yes  No  
Difficulty with urination:  Yes  No

### **Gastrointestinal:**

Loss of Appetite:  Yes  No  
Nausea or vomiting:  Yes  No  
Heartburn/reflux:  Yes  No  
Abdominal pain:  Yes  No  
Diarrhea:  Yes  No  
Constipation:  Yes  No  
Rectal bleeding/blood in stool:  Yes  No

### **Musculoskeletal:**

Joint stiffness:  Yes  No  
Joint pain:  Yes  No  
Joint swelling:  Yes  No  
Muscle weakness:  Yes  No  
Muscle pain/injury:  Yes  No  
Limb pain/injury:  Yes  No  
Back pain/injury:  Yes  No  
Neck pain/injury:  Yes  No  
Difficulty walking:  Yes  No

### **Allergic/Immunologic:**

Sneezing/runny nose:  Yes  No  
Itchy/irritated eyes:  Yes  No  
Nasal/sinus congestion:  Yes  No  
Frequent colds/illness:  Yes  No  
Recurrent pneumonia:  Yes  No  
Recurrent sinus infections:  Yes  No

### **Cardiovascular:**

Chest pain:  Yes  No  
Palpitation/irregular heartbeat:  Yes  No  
Rapid heartbeat:  Yes  No  
Shortness of breath:  Yes  No  
Swelling of feet/ankles/hands:  Yes  No

### **Ear/Nose/Throat/Mouth:**

Hearing Loss or ringing:  Yes  No  
Earaches or drainage:  Yes  No  
Sinus problems:  Yes  No  
Nose bleeds:  Yes  No  
Sinus/face pain:  Yes  No

### **Psychiatric:**

Sadness/Grief:  Yes  No  
Depression:  Yes  No  
Panic/Anxiety:  Yes  No  
Stress:  Yes  No  
Hallucinations:  Yes  No  
Sleep problems:  Yes  No  
Suicidal thoughts:  Yes  No

**Neurological:**

Headaches:  Yes  No  
Concussion:  Yes  No  
Lightheaded/dizzy:  Yes  No  
Fainting/collapse:  Yes  No  
Seizures:  Yes  No  
Numbness/tingling:  Yes  No  
Weakness:  Yes  No  
Tremors:  Yes  No  
Paralysis:  Yes  No  
Head injury:  Yes  No

**Respiratory:**

Coughs:  Yes  No  
Cough/spitting blood:  Yes  No  
Shortness of breath:  Yes  No  
Wheezing:  Yes  No

**Integumentary:**

Rash or itching:  Yes  No  
Skin infection:  Yes  No

**Eyes:**

Eye pain:  Yes  No  
Eye redness:  Yes  No  
Vision changes:  Yes  No  
Blurred/double vision:  Yes  No

Applicant Name: \_\_\_\_\_

Applicant Signature: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Today's Date: \_\_\_\_\_

**Thank you for your interest in the WRRRC program. Please review this application thoroughly for accuracy and completion of all fields prior to its submission. Incomplete applications will take longer to process.**

**--WRRRC Staff**