

OFFICE OF THE DISTRICT ATTORNEY

**Middle Judicial Circuit of Georgia
101 North Main Street, Suite 200
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Swainsboro, GA 30401-0590**

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District Attorney**

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**EARLY INTERVENTION PROGRAM
APPLICATION**

Name: _____
Last First Middle

Maiden Name / Nickname(s): _____

Date of Birth: _____ Home Phone: _____

Email Address: _____ Cell Phone: _____

Address: _____
Street / P.O. Box Apt. # City State Zip

Sex: _____ Race: _____

Driver's License #: _____ State: _____

Are you a U.S. Citizen? (circle one) Yes No

Do you have an attorney for these charges? Yes No

Attorney's Name: _____

List two references (can include a family member, a personal friend, or a work reference):

Name _____ Name _____

Address _____ Address _____

City _____ State/ZIP _____ City _____ State/ZIP _____

Phone _____ Phone _____

Relationship _____ Relationship _____

PLEASE CIRCLE EACH THAT APPLIES TO YOU:

Married Widowed Divorced Separated Never Married Cohabiting

Full-Time Student Part-Time Student Not a Student

Employed Full-Time Employed Part-Time Unemployed Disabled Retired

Personal Monthly Income: 0-500 500-1000 1000-1500 1500-2000 2000+

Household Monthly Income: 0-1000 1000-1500 1500-2000 2000-3000 3000+

PEOPLE WHO LIVE IN YOUR HOUSE:

Name	Age	Sex	Relationship
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Name	Age	Sex	Relationship
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Name	Age	Sex	Relationship
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Name	Age	Sex	Relationship
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Name	Age	Sex	Relationship
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EDUCATION:

High School Name	City	State	Years Attended
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College Name	City	State	Years Attended
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Do you have a high school diploma? Yes No

If no, what grade did you complete in school?

If no, do you have a GED? Yes No

What is your career goal?

EMPLOYMENT HISTORY:

Employer	City, State	Title/Duties	Dates of Employment
Employer	City, State	Title/Duties	Dates of Employment
Employer	City, State	Title/Duties	Dates of Employment
Employer	City, State	Title/Duties	Dates of Employment

CRIMINAL HISTORY: (circle your selection)

Are there any other criminal charges pending against you? Yes No

If yes, please list:

Is this the first time you have been arrested for a felony? Yes No

If no, please list:

WELL-BEING: (circle your selection)

Your general health is: Good Fair Serious concerns

Your employment situation is: Good Fair Serious concerns

Your financial situation is: Good Fair Serious concerns

Your family situation is: Good Fair Serious concerns

Are you currently on any medications? Yes No

If yes, please list medications and reason for taking:

Have you ever had any type of counseling? Yes No

If yes, list your age while in counseling, duration of counseling, and the reason for treatment:

Why should you be accepted into this program? (at least 30 words)

Where do you see yourself in five years? (at least 30 words)

Did you prepare these responses without assistance from another person? Yes No

If no, please identify the person(s) who assisted you: _____

Signing of this application is my statement that the information I have given is true and correct. I have no other criminal history other than what I have listed, and I understand that I may have no additional arrests from this day forward. If I have an additional criminal arrest while enrolled in the program, I will be terminated from the program and my felony case will return to superior court for prosecution.

I also understand I may not use any illegal substances nor unauthorized prescription medication. I may not drink nor possess alcohol if underage. If I am in the program for an alcohol related offense, my alcohol use is prohibited.

Signature of Applicant: _____

Date: _____