INSTRUCTIONS FOR PUBLIC DEFENDER APPLICANTS

1. The application MUST be completely filled out. Each page must be initialed to show that the Applicant has both read and understood the contents of each page.

2. If you are incarcerated, you MUST provide your home address, not the prison.

3. The application MUST be signed where indicated. Your application will not be accepted unless it is completed and signed.

4. You MUST provide Proof of income for EVERY wage earner in the household at the time of application. Your application will not be processed unless all proof of income is provided.

5. You MUST provide all paperwork relative to your case; for example, Criminal Complaint, PFA Violation and original PFA paperwork, and Truancy paperwork. Your application will not be processed unless all paperwork is provided.

6. Upon initial application which **MUST BE SUBMITTED AT LEAST FORTY-EIGHT (48) HOURS** prior to the defendant's hearing in Central Court, the Public Defender's Office shall investigate the applicant's eligibility for free legal services.

7. **THE SCOPE OF THE PUBLIC DEFENDER'S REPRESENTATION SHALL CEASE UPON A FINAL DECISION, VERDICT, ACQUITTAL, OR DISMISSAL IN THE APPLICANT'S CASE BY THE COURT OF COMMON PLEAS OF LACKAWANNA COUNTY OR LOWER MAGISTERIAL DISTRICT COURT OF LACKAWANNA COUNTY.**

   THE SCOPE OF THE PUBLIC DEFENDER'S REPRESENTATION SHALL NOT OBLIGATE HIM OR HER TO REPRESENT THE APPLICANT IN ANY MATTER, PROCEEDING OR APPEAL TO A HIGHER COURT.

   IF THE APPLICANT CHOOSES TO PROCEED TO APPEAL A FINDING BY THE COURT TO A HIGHER AUTHORITY, THEN THE PUBLIC DEFENDER SHALL PROVIDE THE APPLICANT WITH SAMPLE DOCUMENTATION TO REVIEW AND UTILIZE IN PERFECTING THE APPLICANT'S APPEAL. HOWEVER, THIS DOES NOT PRECLUDE THE PUBLIC DEFENDER, AFTER A REVIEW WITH THE CHIEF PUBLIC DEFENDER, TO PURSUE APPEALS WITH THE APPLICANT'S AGREEMENT.

8. **IF THE INFORMATION SUPPLIED IN THIS APPLICATION IS DETERMINED TO BE FALSE, SUCH DETERMINATION COULD HAVE SEVERE CRIMINAL AND/OR CIVIL FINANCIAL CONSEQUENCES. IF THE APPLICANT BECOMES INELIGIBLE FOR FREE LEGAL SERVICES BY OBTAINING EMPLOYMENT, INCOME FROM ANOTHER SOURCE OR ASSETS, WHILE THE CASE IS PENDING, THE APPLICANT MUST IMMEDIATELY NOTIFY THE PUBLIC DEFENDER'S OFFICE OF THE CHANGE IN STATUS OR CIRCUMSTANCES.**

   IN THE EVENT A DETERMINATION OF FINANCIAL INELIGIBILITY IS MADE FOR ANY REASON AFTER THE INITIAL APPLICATION FOR FREE SERVICES HAS BEEN APPROVED, IT SHALL BE THE APPLICANT'S RESPONSIBILITY TO PAY LACKAWANNA COUNTY FOR THE SERVICES PROVIDED.

9. **THE PUBLIC DEFENDER'S OFFICE RESERVES THE RIGHT TO REQUIRE THE SUBMISSION OF ANY DOCUMENTATION DEEMED NECESSARY TO SUPPORT THE INFORMATION REQUESTED IN THIS APPLICATION.**

CONTACT INFORMATION

Public Defender's Office
Lackawanna County Court House
200 North Washington Avenue, 1st Floor
Scranton, PA 18503

Telephone No.: (570) 963-6761
Fax No.: (570) 963-6338

Assistant Public Defender assigned to your case: _____

_____INITIALS

PUBLIC DEFENDER'S OFFICE

Lackawanna County Courthouse, Scranton, PA

APPLICATION FOR ASSIGNMENT OF LEGAL COUNSEL

TODAY'S DATE: _____

NAME: _____ GENDER: _____

ADDRESS: _____

CITY: _____ STATE:_____ ZIP CODE: _____

PHONE: (H) _____ (W) _____ (CELL) _____

AGE: _____ DATE OF BIRTH: _____ SOC. SEC. NO. _____

DRIVER'S LICENSE NUMBER: _____ STATE: _____

HOW FAR DID YOU GO IN SCHOOL? _____

DO YOU READ AND WRITE THE ENGLISH LANGUAGE? _____

ARE YOU A UNITED STATES CITIZEN? _____

HAVE YOU EVER SERVED IN THE ARMED FORCES OF THE UNITED STATES (Army, Navy, Air Force, Marines, Coast Guard, Reserves)_____

HAVE YOU EVER BEEN IN A MENTAL INSTITUTION OR RECEIVED TREATMENT FOR A MENTAL DISEASE? _____

LIST THE NAMES AND AGES OF THE PEOPLE YOU LIVE WITH: _____

_____

_____

PROVIDE A CONTACT PERSON WHO WILL ALWAYS KNOW YOUR WHEREABOUTS

NAME: _____ RELATION: _____

ADDRESS: _____

PHONE: (H) _____ (W) _____ (CELL) _____

1. **CHARGES**

LIST ALL CRIMINAL CHARGES AGAINST YOU: _____

_____

_____

PRELIMINARY HEARING DATE: _____

BAIL (check one) ROR_____ AMOUNT_____ UNSECURED? ☐ or ☐

HAVE YOU CONSULTED A PRIVATE ATTORNEY FOR THIS MATTER? ☐ ☐

IF YES, HAVE YOU PAID A RETAINER FEE? ☐ ☐

_____**INITIALS**

2. **EMPLOYMENT**

ARE YOU PRESENTLY WORKING? YES☐ NO☐

IF YES: POSITION: _____

EMPLOYER'S NAME: _____

ADDRESS: _____

WAGE OR SALARY: _____

HOURS YOU WORK PER WEEK: _____ HOURLY RATE OF PAY: _____

IF NO: LAST DAY WORKED: _____

LAST 5 PLACES WORKED AND DATES WORKED:

_____

_____

_____

_____

_____

HOW ARE YOU SUPPORTING YOURSELF? _____

_____

_____

_____

3. **FINANCIAL STATUS**

ARE YOU CURRENTLY RECEIVING PUBLIC ASSISTANCE? YES☐ NO☐ IF SO, WHAT ASSISTANCE AND HOW MUCH PER MONTH: _____

_____

DO YOU HAVE ANY SOURCE OF INCOME SUCH AS:

ALIMONY YES☐ NO☐ IF SO, HOW MUCH PER MONTH: _____

RENTAL INCOME YES☐ NO☐ IF SO, HOW MUCH PER MONTH: _____

UNEMPLOYMENT COMP. YES☐ NO☐ IF SO, HOW MUCH PER MONTH: _____

WORKMAN'S COMP. YES☐ NO☐ IF SO, HOW MUCH PER MONTH: _____

DISABILITY YES☐ NO☐ IF SO, HOW MUCH PER MONTH: _____

SSI YES☐ NO☐ IF SO, HOW MUCH PER MONTH: _____

RETIREMENT BENEFITS YES☐ NO☐ IF SO, HOW MUCH PER MONTH: _____

DO YOU HAVE ANY CASH ON HAND? YES☐ NO☐

IF YES, HOW MUCH? _____

LIST ALL VEHICLES YOU OWN/REGISTERED TO YOU (YEAR, MAKE, MODEL):

TYPE: _____ VALUE: _____ LOAN AMOUNT: _____

TYPE: _____ VALUE: _____ LOAN AMOUNT: _____

TYPE: _____ VALUE: _____ LOAN AMOUNT: _____

TYPE: _____ VALUE: _____ LOAN AMOUNT: _____

GIVE AMOUNT OF CHILD SUPPORT YOU PAY: _____

GIVE AMOUNT OF CHILD SUPPORT YOU RECEIVE: _____

LIST MONTHLY INCOME OF EVERY PERSON IN YOUR HOUSEHOLD:

NAME MONTHLY INCOME RELATION

_____

_____

_____

_____

TOTAL HOUSEHOLD INCOME (INCLUDING YOUR OWN): $_____PER MONTH TOTAL

HOUSEHOLD INCOME FROM PAST 12 MONTHS: $_____

MARITAL STATUS: _____

NAME/ADDRESS OF SPOUSE: _____

_____

IS YOUR SPOUSE WORKING? YES☐ NO☐ MONTHLY INCOME:_____

NAMES AND AGES OF YOUR CHILDREN:_____

_____

_____

ASSETS BANK AND OTHER ACCOUNT BALANCE INFORMATION: (CHECK ALL THAT APPLY)

☐CHECKING BALANCE: _____

☐SAVINGS BALANCE: _____

☐MONEY MARKET BALANCE: _____

☐CERTIFICATES OF DEPOSIT VALUE: _____

☐BOND VALUE: _____

☐STOCK VALUE: _____

☐OTHER ACCOUNTS: _____

REAL ESTATE HOLDINGS: (list all real estate that you own individually or jointly)

TYPE: _____ VALUE: _____ MORTGAGE AMOUNT:_____

TYPE: _____ VALUE: _____ MORTGAGE AMOUNT: _____

_____**INITIALS**

TYPE: _____ VALUE: _____ MORTGAGE AMOUNT: _____

TYPE: _____ VALUE: _____ MORTGAGE AMOUNT: _____

HAVE YOU SOLD ANY REAL ESTATE OWNED INDIVIDUALLY OR JOINTLY WITHIN THE PAST THREE (3) YEARS? YES☐ NO☐

IF YES, TYPE_____ PURCHASE PRICE_____ SALE AMOUNT_____

RECREATIONAL OR OTHER VEHICLES: (LIST ALL OTHER VEHICLES OF WHATEVER TYPE YOU OWN INDIVIDUALLY OR JOINTLY)

TYPE: _____ VALUE: _____ LOAN AMOUNT: _____

TYPE: _____ VALUE: _____ LOAN AMOUNT:_____

TYPE: _____ VALUE: _____ LOAN AMOUNT: _____

TYPE: _____ VALUE: _____ LOAN AMOUNT: _____

LIST ANY OTHER ASSETS INCLUDING COINS, STAMPS, JEWELRY, GUNS, OR OTHER ITEMS OF VALUE THAT MAY BE CONVERTED TO CASH.

_____

_____

_____

DO YOU HAVE ANY CLAIMS OR SUITS PENDING TO RECOVER COMPENSATION OR MONEY DAMAGES? YES☐ NO☐ IF YES, EXPLAIN: _____

_____

_____

CREDIT CARDS: (LIST ALL CREDIT SOURCES YOU HAVE INCLUDING BALANCE AND AVAILABLE CREDIT; ATTACH ADDITIONAL SHEET IF NECESSARY):

CREDITOR NAME:_____ BALANCE:_____ CREDIT LIMIT:_____

CREDITOR NAME:_____ BALANCE:_____ CREDIT LIMIT:_____

CREDITOR NAME:_____ BALANCE:_____ CREDIT LIMIT:_____

CREDITOR NAME:_____ BALANCE:_____ CREDIT LIMIT:_____

4. **ALL PRIOR CONVICTIONS** (WHETHER IN STATE, OUT OF STATE, FEDERAL, JUVENILE OR ADULT, AND PRIOR ARDS OR OTHER EXPUNGEMENTS) (IF ANY):

_____

_____

_____

DO YOU HAVE ANY OTHER PENDING CRIMINAL MATTERS? YES☐ NO☐

IF YES, WHAT IS THE STATUS? _____

_____**INITIALS**

ARE YOU CURRENTLY ON SUPERVISION? YES☐ NO☐

IF YES, IS IT FEDERAL, STATE, OR COUNTY? _____

IS YOUR SUPERVISION UNDER AN ARD PROGRAM, DRUG COURT PROGRAM, OR MENTAL HEALTH COURT PROGRAM? YES☐ NO☐

IF YES, WHICH PROGRAM: _____

5. **SCOPE OF THE PUBLIC DEFENDER'S REPRESENTATION (READ CAREFULLY!!!)**

THE SCOPE OF THE PUBLIC DEFENDER'S REPRESENTATION SHALL CEASE UPON A FINAL DECISION, VERDICT, ACQUITTAL, OR DISMISSAL IN THE APPLICANT'S CASE BY THE COURT OF COMMON PLEAS OF LACKAWANNA COUNTY OR LOWER MAGISTERIAL DISTRICT COURT OF LACKAWANNA COUNTY.

THE SCOPE OF THE PUBLIC DEFENDER'S REPRESENTATION SHALL NOT OBLIGATE HIM OR HER TO REPRESENT THE APPLICANT IN ANY MATTER, PROCEEDING OR APPEAL TO A HIGHER COURT.

IF THE APPLICANT CHOOSES TO PROCEED TO APPEAL A FINDING BY THE COURT TO A HIGHER AUTHORITY, THEN THE PUBLIC DEFENDER SHALL PROVIDE THE APPLICANT WITH SAMPLE DOCUMENTATION TO REVIEW AND UTILIZE IN PERFECTING THE APPLICANT'S APPEAL. HOWEVER, THIS DOES NOT PRECLUDE THE PUBLIC DEFENDER, AFTER A REVIEW WITH THE CHIEF PUBLIC DEFENDER, TO PURSUE APPEALS WITH THE APPLICANT'S AGREEMENT.

6. **IF THE INFORMATION SUPPLIED IN THIS APPLICATION IS DETERMINED TO BE FALSE, SUCH DETERMINATION COULD HAVE SEVERE CRIMINAL AND/OR CIVIL FINANCIAL CONSEQUNECES. IF THE APPLICANT BECOMES INELIGIBLE FOR FREE LEGAL SERVICES BY OBTAINING EMPLOYMENT, INCOME FROM ANOTHER SOURCE OR ASSETS, WHILE THE CASE IS PENDING, THE APPLICANT MUST IMMEDIATELY NOTIFY THE PUBLIC DEFENDER'S OFFICE OF THE CHANGE IN STATUS OR CIRCUMSTANCES.**

IN THE EVENT A DETERMINATION OF FINANCIAL INELIGIBILITY IS MADE FOR ANY REASON AFTER THE INITIAL APPLICATION FOR FREE SERVICES HAS BEEN APPROVED, IT SHALL BE THE APPLICANT'S RESPONSIBILITY TO PAY LACKAWANNA COUNTY FOR THE SERVICES PROVIDED.

_____ _____

Signature **Date**

VERIFICATION

I verify that the statements made in the Application for Assignment of Legal Counsel are true and correct. I understand that false statements herein are made subject to the penalties of 18 Pa. C.S.A. §4904, relating to unsworn falsification to authorities.

_____

APPLICANT'S SIGNATURE

LACKAWANNA COUNTY PUBLIC DEFENDER'S OFFICE

Authorization and Release

To whom it may concern:

I hereby authorize and request you to disclose and give copies to my attorney, the Public Defender of Lackawanna County, Pennsylvania, or any of his assistants or representatives, any and all records and information concerning me which you have in your possession, including but not limited to the following:

- Hospital records and records of physicians, nurses, and other personnel (including narrative summaries or medical diagnosis, prognosis and treatment; charts; notes of interviews; histories; and psychiatric or psychological evaluations),
- Financial information (including records as to earnings, assets and liabilities), ☐ Personal information (including personnel files; copies of reports made to any other person or agency; and statements),
- Military records (including medical and psychological diagnosis and prognosis reports of treatment; service history; and records of disciplinary actions, if any),
- And any related information.

This shall constitute sufficient Power of Attorney for obtaining such information, records, and reports. In consideration of your disclosure, I hereby release you (and, as appropriate, the institute you represent) from any and all liability arising from such disclosure.

A photocopy of this authorization shall be considered as effective and valid as the original.

Date: _____ Signed:_____

Print Name:_____

AUTHORIZATION TO USE OR DISCLOSE
{PERSONAL AND/OR HEALTH CARE} INFORMATION

Subject's Name: _____
File/Claim/Control Number: _____
Date of Birth:_____

1. I authorize the use or disclosure of the above named individual's personal/health-information as described below in paragraph three (3).

2. The following individual or organization is authorized to make disclosure:
Name: _____
Address: _____

3. The type and amount of information to be used or disclosed is as follows (include dates where appropriate):

_____All Records
_____Employment Records
_____Insurance Records
_____Medical Records
_____Official or Governmental Records
_____Retirement Records
_____Vocational records
_____Educational Records
_____Financial Records
_____Legal Records
_____Military Records
_____Pension Records
_____Tax Records
_____Wage and Earnings Records
_____Other (specify): Any and All_____; and any and all other records or correspondence in your possession in whatever format they are maintained.

4. I understand that the information in my personal records may include information relating to such matters as sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, treatment for alcohol and drug abuse, and genetic testing. This authorization applies to all of those records.

5. This information may be disclosed to and used by the following individual or organization:

NAME: **LACKAWANNA COUNTY PUBLIC DEFENDER'S OFFICE**
ADDRESS: **200 N. Washington Avenue, Scranton, Pennsylvania 18503**
PHONE: **(570) 963-6761 / FAX (570)963-6338**

for the purpose of verification, review, and evaluation by my attorney, or his designated representatives, with respect to pending proceedings which have been, or future proceeding which may be, commenced on my behalf.

6. ***I understand that I have a right to revoke this authorization at any time.*** I understand that if I revoke this authorization I must do so in writing and present my written revocation to the records/health information management department or designated representative. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. ***Unless otherwise revoked, this authorization will expire on the following date, event or condition: three (3) years from the date shown below.*** If I fail to specify an expiration date, event or condition this authorization will expire in six months.

_____**INITIALS**

7. ***I understand that authorizing the disclosure of this personal information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment.*** I understand that I may inspect or copy the information to be used or disclosed, as allowed by federal law. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and that the information may not be protected by Federal confidentiality rules in that circumstance. I understand that if I have questions about disclosure of my personal information, I can contact the records custodian or other designated representative of this provider identified in paragraph two (2), above, directly for more information.

8. I intend that this authorization is fully HIPPA-compliant. This authorization should be read and be construed to be HIPPA-compliant. A photocopy of this authorization may be substituted for the original.

DO NOT SIGN THIS AUTHORIZATION UNLESS YOU HAVE READ IT AND UNLESS YOU UNDERSTAND THE CONSEQUENCES OF SIGNING IT. YOUR SIGNATURE WILL BE CONCLUSIVE PROOF THAT YOU HAVE READ AND UNDERSTOOD THE CONSEQUENCES OF SIGNING THIS DOCUMENT.

_____ _____

Signature of Individual or Legal Representative **Date:**