

**SUPERIOR COURT OF NEW JERSEY
CRIMINAL DIVISION**

APPLICATION TO THE DRUG COURT PROGRAM

OCEAN VICINAGE

DATE OF APPLICATION: _____

NAME: _____ ALIAS: _____

ADDRESS: _____ TELEPHONE #: _____

CITY: _____ STATE: _____ ZIP: _____

HOW LONG AT THIS ADDRESS: _____ CITIZENSHIP STATUS: _____

CO-HABITANT: _____ RELATIONSHIP: _____

PREVIOUS ADDRESS: _____

NEXT OF KIN: _____ RELATIONSHIP: _____ TELEPHONE #: _____

DEFENSE ATTORNEY: _____ TELEPHONE #: _____

CURRENT CHARGES: _____ INDICTMENT #: _____

PG #: _____

NEXT COURT EVENT: _____ DATE: _____ JUDGE: _____

DATE OF ARREST: _____ LOCATION: OF ARREST _____

EMPLOYER: _____ TELEPHONE#: _____

EMPLOYER ADDRESS: _____

RACE: _____ SEX: _____ DOB: _____ SOC SEC.#: _____

SBI#: _____ FBI#: _____ HEIGHT: _____ WEIGHT: _____

DRIVER'S LICENSE#: _____ EYE COLOR: _____ HAIR COLOR: _____

DISTINGUISHING MARKS: _____ VETERANS STATUS _____

PRESENTLY INCARCERATED: NO _____ YES _____ JAIL#: _____

DETAINERS? NO _____ YES _____ JURISDICTIONS: _____

ON PROBATION? NO _____ YES _____ PAROLE? NO _____ YES _____ PO'S NAME: _____

PRIOR CONVICTIONS (ADULT)

<u>DATE</u>	<u>CHARGES</u>	<u>COURT</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

JUVENILE RECORD: _____ YES _____ NO

LOCATION OF COURT: _____

I understand that it is my responsibility, if I am not incarcerated, to contact the Substance Abuse Evaluator to schedule an appointment. Failure to schedule or appear for this appointment could result in my application for Drug Court being denied. I am aware the Evaluator will make a decision as to the level of care that is needed (i.e.: outpatient, short term residential, or long term residential).

SIGNATURE OF DEFENDANT: _____ DATE: _____

This application will not be considered for admission into Drug Court unless the following certification has been completed: I hereby certify that I have fully explained the Drug Court program and that I have reviewed with him/her the contents of the Drug Court Participants Handbook and Participation Agreement.

DEFENSE COUNSEL SIGNATURE

DATE

- Public Defender
- Retained Counsel

Drug Court Public Defender: _____ Date: _____

State of New Jersey Superior Court

Consent for the Release of Confidential Treatment Information

I, _____ do hereby give consent and authorize the staff team members
(Name of Participant)

of the Ocean Vicinage Adult Drug Court*, to have reciprocal verbal communication and to exchange written records with

(Name and title of contact person)

(Organization, street address, city, state, zip with whom disclosure is to be made)

*In addition to the T.A.S.C. / Substance Abuse Evaluator this includes: Superior Court Judge, Assistant Prosecutor, Assistant Deputy Public Defender, Private Attorney (if indicated), Drug Court Coordinator, Probation Supervisor and Officer(s), Team Leader, Court Clerk and Treatment Program representative(s).

I DO GIVE
CONSENT
(Initial line)

- 1. Addiction Severity Index (ASI) Assessment
2. Bio-Psycho-Social Assessment
3. Current Medications
4. Results of Psychological Evaluation(s)
5. Discharge Summary
6. HIV Test Results
7. Medical and Physical Examination Results
8. Other Medical Test Results
9. Admission / Intake Summary
10. Program Attendance: session date, type, frequency
11. Results of Psychiatric Evaluation(s)
12. Psychiatric or Psychological Progress Reports
13. Summary of Diagnosis
14. Current Symptoms and Treatment Plan
15. Statement of Treatment Prognosis
16. Statement of Treatment Status/ Progress
17. Results of drug testing (including and not limited to urine, saliva, breath and perspiration)
18.
19.
20.

Consent for the Release of Confidential Treatment Information

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I UNDERSTAND (Initial Line)

➤ *The purpose or need for such disclosure authorized herein is to comply with conditions of Court order, assist with assessment and appropriate referral, and / or to keep the Court informed of my status in treatment.*

➤ *I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent will remain in force for one (1) year.*

➤ *I understand that my continued participation in Drug Court is conditioned upon ongoing communication between the Court and my treatment provider.*

➤ *I understand I will be asked to renew this consent on, at minimum, an annual basis, throughout the course of my participation in Drug Court and enrollment in treatment.*

➤ *I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act (HIPAA), 45 CFR Parts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.*

Participant's Signature

Date

PRINT Participant Name

Signature of Witness

Date

(PRINT Witness Name and Title)

*State of New Jersey Superior Court
Consent for the Re-Disclosure of Confidential Alcohol &
Drug Treatment or Other Health Information*

Client Date of Birth: ____/____/____

Social Security No: ____ - ____ - ____

I, _____ do hereby consent and authorize the staff team members
(Name of Participant)

of the Ocean Vicinage Adult Drug Court, to provide the following documents from
my records in the Court file:

*(**Specific information to be released under secondary release authorization requires separate, specific consent needed for medical, psychiatric, psychosocial progress notes and HIV records)*

which were obtained by the Drug Court Team from the following facility:

(Name of facility from which requested files originated)

to the following facility and/or person

(Name of facility to which records may be sent)

for the purpose of:

(Specific purpose for authorizing secondary release of information to above facility)

- I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent will remain in force for no more than a period of 90 days from the date below, in order to effectuate the purpose for which it was given.
- I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act (HIPAA), 45 CFR Parts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

Date of Signature

Client's Signature

Date of Witness Signature

Witness Signature, Title