ESSEX COUNTY PROSECUTOR'S OFFICE
MENTAL HEALTH DIVERSION PROGRAM

Application to participate in the Essex County Prosecutor's Office Mental Health Diversion Program

The Essex County Prosecutor's Office has established a diversionary program for individuals with serious mental illness. The goal is to work with appropriate individuals who agree to comply with supervised treatment to limit or avoid certain convictions or incarceration based on continued cooperation.

Applicant Name:______________________________
Aliases: ______________________________
Date of Birth: ____________ Age: ________ Social Security Number: ______________
Address/Apt: ______________________________
Telephone Number: ______________ Email: ______________
Alternative Contact Person/Relationship: ____________________
Alternative Contact Address/Telephone: ____________________

Promis No.______________
Complaint No. ______________
Indictment No. ______________
Charges:______________

Promis No.______________
Complaint No. ______________
Indictment No. ______________
Charges:______________

PLEASE HAVE APPLICANT READ EACH ITEM LISTED BELOW, INITIAL PAGE ONE AND SIGN AND DATE PAGE 2.

1. I am requesting and acknowledge that I am being considered for acceptance into the Essex: County Prosecutor's Office Mental Health Diversion Program ("Diversion Program") should I qualify.

2. I am a resident of Essex: County, New Jersey.

3. I acknowledge and am aware that acceptance into the Diversion Program is determined on a case-by-case basis, there is no right to acceptance, nor is there a guarantee that I will be accepted.

4. I acknowledge and am aware that the Diversion Program is voluntary and that I may choose at any time.to decline and thus have my case proceed by traditional criminal prosecution.

5. I agree to participate in the evaluation process to determine if I qualify for the Diversion Program and to help me decide if I want to enter the Program should I qualify.

6. I agree to cooperate in the intake process, including filling out forms and providing releases so that the Diversion Program, Mental Health Providers and Substance Abuse Treatment Providers can obtain relevant information about me, including medical, mental health, and substance abuse treatment information.

7. I agree to participate in psychological, substance abuse, and risk evaluations that may include completing written forms and tests and interviews with mental health and/or substance abuse professionals.

____

Applicant Initials

I acknowledge and am aware that I can terminate this process by informing the program in writing that I do not want to be further considered for acceptance.

8. I acknowledge and am aware that if I am accepted into the Diversion Program that I may be required to:

• Take medication as prescribed • Submit to medication management and monitoring • Abstain from illegal drugs and excessive alcohol • Submit to random drug screening • Attend therapy and counseling as directed • Remain in Essex County and inform the team if I move or become homeless • Agree to any no contact orders with specific people or places • Shall not possess any weapons	• Not commit any new offenses but agree to report any law enforcement contact to the Team • Submit to graduated sanctions for **willful noncompliance** with the terms of my participation, including but not limited to increased court reporting, frequent drug testing, essay writing, community service, and/or jail time • Agree to or fulfill other conditions as may be required or assigned by the Diversion Program Team or the Court.

9. I understand that during the application process and if I am accepted into the Diversion Program, all applicable time limits of a traditional prosecution will be delayed. I further understand that if I am terminated from the Program, the tolling of any time limits will also terminate and the criminal case against me shall proceed.

10. I understand that if I am accepted into the Diversion Program, I will be required to participate in the program for a minimum of one (1) year from the date of acceptance. The maximum time will be determined by the maximum sentence exposure I am subject to on the most serious crime or offense I have been charged with. The time that I will be required to participate in the program will be determined by the Essex County Prosecutor's Office with my treatment team, who will continually evaluate my progress during my participation in the Program.

11. I understand that I may be required to plead guilty to some or all of the charges filed against me as a condition of acceptance into the Program.

12. I understand that some of the information about my case may be used for statistical purposes to evaluate the Program, but that any information used will be anonymous.

13. I understand that during this application process, and if I am accepted into the Program, I must continue to attend all scheduled court appearances for which I received proper notice. I acknowledge that if I fail to appear for any court proceedings for which I have received proper notice, a warrant for my arrest may be issued for my arrest. I understand that if I move, it is my duty to ensure that I provide the court, probation, and my treatment providers my most up-to-date address.

14. I acknowledge and am aware that should I successfully complete the requirements of the Program, my charges will be dismissed or downgraded if I was accepted under track one, or (2) my custodial sentence will be changed to a non-custodial probation.

15. I understand that I must sign and attach The Essex County Prosecutor's Office Mental Health Diversion Program Release of Psychiatric, Psychological, Mental Health Treatment, Substance Abuse, Addiction, Medical and/or Hospital Information and Records, "Release", in order to be evaluated for the Program and have signed and attached it hereto.

____
Applicant Initials

16. I understand and acknowledge that the uses and disclosures of my personal health information are protected by HIPAA and various privacy laws. I agree that my personal health information may be obtained by members of the Mental Health Diversion Program and may be redisclosed only to persons associated with the Mental Health Diversion Program. Possible persons associated with the program include but are not limited to Superior Court Judge(s), The Public Defender's Office, Probation Department, Essex County Prosecutor's Office personnel associated with the MHDP, the Essex County Jail, MHA of Essex and Morris Counties, and related community providers.

17. I understand that any personal health information is to be used solely for acceptance into and continued participation in the Mental Health Diversion Program. If I am not accepted or am terminated from the Program, any information including statements made by me or evidence derived therefrom shall not be used in any criminal proceeding against me, unless those records are obtained by separate release or court order. Any records obtained by the Program's clinical staff shall be distributed to my attorney(s).

18. I understand that my participation in the Program is conditioned upon my signing the Mental Health Diversion Program's Authorization for Release of Patient Records and that throughout the duration of my participation, including any subsequent time on probation, I am authorizing members of the Program to access my personal health information. I understand that I am no longer eligible for the program if I do not sign or If I revoke the Authorization for Release.

Applicants Signature ____ Date________________

Defense Counsel's Name ____ Date _______________

Address____

Telephone No. _________________ Email:___________________________ Fax No. _________________________

ESSEX COUNTY PROSECUTOR'S OFFICE
MENTAL HEALTH DIVERSION PROGRAM

AUTHORIZATION FOR RELEASE OF PATIENT RECORDS TO ESSEX COUNTY PROSECUTOR'S OFFICE MENTAL HEALTH DIVERSION PROGRAM

Patient Name__________________________________ **Birthdate** _________ **SSN** ____________________

1. I authorize ______________________________________ to disclose any psychiatric, psychological, clinical, and substance abuse records to any member of the Essex County Prosecutor's Office Mental Health Diversion Program treatment team, including but not limited to Essex County Hospital Center Clinical Staff, Essex County Probation Department – Mental Health Unit, NJ Office of the Public Defender, and the Hon. Verna G. Leath, J.S.C. or her designees. Records requested should be sent to: ____

   ____

   I further authorize that electronic copies may be sent to: ____

2. I understand that those records will include but are not limited to: intake records, psychosocial evaluations, diagnoses, treatments, medications, attendance, behavioral contracts, discharge records and recommendations from the date of my intake until present. I authorize the following records to be disclosed:

   ____

   ____

   ____

3. The purpose of this disclosure is to assist in my legal case.

   I understand that if my medical records contain information related to the history, diagnosis and or treatment of any psychiatric problem, mental illness, drug abuse, alcoholism, sexually transmitted or communicable disease, AIDS, or HIV, and that my signing this document authorizes _______________ ____________________________________ to release that information. I know that New Jersey has statutory privilege accorded to confidential communication between a licensed doctors, psychologists, and other mental health or medical professionals and that my signing this form waives this privilege.

   A check here indicates that I believe my medical records may contain DNA test results or other genetic information. Such information is specially protected by New Jersey laws and I will be contacted for specific consent prior to the release of this information.

4. This authorization may be revoked at any time by sending written notice to the Director of Medical Services at ____, except to the extent that it has already been relied upon and action has already been taken. If not previously revoked, this consent will terminate **(3) YEARS FROM TODAY**.

5. ____________________________________ will not make decisions concerning treatment, payment, enrollment of eligibility for benefits based on signing, refusing to sign, or revoking this authorization.

6. I acknowledge and understand that uses and disclosures of my health information authorized by this document may be subject to redisclosure by the recipient and may not be protected by privacy and confidentially laws.

Signature of Patient or legal guardian ____ Date: ________________