

**COURT OF COMMON PLEAS
Cumberland County, Pennsylvania
Application Instructions**

Drug Treatment and DUI Court Application Instructions:

Cumberland County Drug Court will review the offenses pertaining to each referral made to the program. Initial eligibility will be determined by the District Attorney's Office.

The following criteria have been established to identify persons who may qualify for admission:

- Offender has a verifiable history of substance abuse.
- Offender is a Cumberland County resident, age 25 years or older.
- Offender has a non-violent criminal history.
- Offender commits an offense related to substance abuse (not necessarily a DUI or drug offense).
- Offender voluntarily agrees to participate in, and be subject to rules, regulations and sanctions of Drug Treatment and DUI Court.

DUI Court will also consider an offender's prior record when determining eligibility. A record of excluded offenses will not result in immediate dismissal of the referral; however, may it be considered as an exclusionary factor. Final eligibility shall be at the discretion of the DUI Court Team.

To apply, please complete and sign the application and both waivers attached and return to:

Criminal Justice Services
20 North Hanover Street, Suite 300
Carlisle, PA 17013
Fax: 717.240.7791
Email: treatmentcourtapplications@cumberlandcountypa.gov

TOMS Court Application Instructions:

Cumberland County TOMS (Together Optimizing Mental-Health Solutions) will review the offenses pertaining to each referral made to the program. Initial criteria will be determined by the District Attorney Office.

The following criteria have been established to identify persons who may qualify for admission:

- Applicant must be a resident of Cumberland County, Pennsylvania.
- Applicant must have a persistent serious mental illness primary diagnosis falling within the spectrum of Major Depressive Disorder, Bipolar Disorder, Schizophrenia, Schizoaffective Disorder, or Other Specified Schizophrenia Spectrum and Other Psychotic Disorder.
 - Rarely, but with sufficient cause, other disorders may be considered.
 - If applicants do not have a current diagnosis (a diagnosis made in excess of 2 years without ongoing treatment is considered outdated), she/he must complete an appropriate psychological/psychiatric evaluation to document a diagnosis.

- The applicant's criminal charges must demonstrate a relationship between the diagnosed mental illness and the criminal behavior.

TOMS Court will not fund evaluations for any applicant. Indigent applicants, without any insurance source, may qualify for an evaluation at the expense of Cumberland/Perry MH.IDD. Participants who do not qualify for county-funded services will be responsible for all costs associated with obtaining an evaluation.

Applications must include:

- Completed application form.
- Signed waivers attached.
- Any of the following documents supporting a qualifying diagnosis:
 - Psychiatric evaluations (within the past 2 years)
 - Psychological evaluations (within the past 2 years)
 - Progress notes from a treating physician (within the past 2 years)
 - A letter from a treating psychologist/psychiatrist indicating the diagnosis, period of treatment, and level of compliance
 - A 20-page evaluation is needed that was completed within 2 years. (*A letter from a medical provider will **not** suffice as supporting documentation for a qualifying diagnosis. **This documentation is needed for the application to be processed.**)

Applications should be submitted to:

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20 North Hanover Street, Suite 300
Carlisle, PA 17013
Fax: 717.240.7791
Email: treatmentcourtapplications@cumberlandcountypa.gov

COURT OF COMMON PLEAS
Cumberland County, Pennsylvania
Application to the Specialty Courts

Check which apply: ☐ TOMS Court (Mental Health)
☐ Drug Treatment Court
☐ DUI Court

LEGAL REPRESENTATION

Select one: ☐ Private Attorney ☐ Public Defender ☐ Pro Se

Attorney's Name:

Firm (if private):

Address:

Street

City

State

Zip Code

Phone:

Fax:

Email:

DEFENDANT INFORMATION

Name:

First

Middle

Last

Alias or Maiden Name:

Physical address:

Street

City

State

Zip Code

Mailing address: Same as above ☐

Street/PO Box

City

State

Zip Code

Race: ☐ African American ☐ Alaskan Native ☐ Asian/Pacific Islander ☐ Caucasian ☐ Hispanic/Latino ☐ Multi-Racial ☐ Native American ☐ Other:

Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown/Unreported		Sex assigned at birth: <input type="checkbox"/> Male <input type="checkbox"/> Female
Preferred gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male <input type="checkbox"/> Transgender Female <input type="checkbox"/> Gender Variant/Non-Conforming <input type="checkbox"/> Non-Binary <input type="checkbox"/> Other:		
Pronouns: <input type="checkbox"/> He/Him/His <input type="checkbox"/> She/Her/Hers <input type="checkbox"/> They/Them/Theirs <input type="checkbox"/> Other:		
Date of birth:	Social Security Number:	
Cell phone:	Emergency Contact Name/Phone Number:	
Work phone:	Email:	
Primary language spoken: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other:		
Disability Accommodations: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, state need:		
Living arrangements: <input type="checkbox"/> Divorced* <input type="checkbox"/> Living Together* <input type="checkbox"/> Married* <input type="checkbox"/> Single <input type="checkbox"/> Separated* <input type="checkbox"/> Widowed* *Name of spouse or partner:		
CRIMINAL/CHARGE INFORMATION		
List all pending dockets below. You may attach an additional page if necessary.		
Docket Number	OTN	Offense(s)
Are you currently serving a County Restrictive Probation sentence? <input type="checkbox"/> Yes <input type="checkbox"/> No		

On probation? <input type="checkbox"/> Yes <input type="checkbox"/> No	On parole? <input type="checkbox"/> Yes <input type="checkbox"/> No	Probation / Parole officer's name: Agency:	
Do you have any matters pending in any other court? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of court(s):			
Have you ever participated in a treatment court (Drug, DUI, Mental Health, Veterans, etc.) before? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of court:			
Do you have any detainers? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list jurisdictions:			
Are there any outstanding court orders pending against you? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list orders: ("Court orders" include but are not limited to: protection from abuse (PFA) orders, bench warrants, support orders, other judgments.)			
SUBSTANCE ABUSE HISTORY			
Have you ever used drugs or alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No		Have you ever received substance use treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Please list all treatment you have received. You may attach an additional page if necessary.			
Facility	Level of Care <i>(Inpatient, IOP, OP, etc)</i>	Dates	Completed Successfully? Sobriety Time?

1 st drug of choice		2 nd drug of choice		3 rd drug of choice	
Have you ever been an IV drug user? <input type="checkbox"/> Yes <input type="checkbox"/> No			Are you currently an IV drug user? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Age began using drugs:			Age began using alcohol:		
Are you currently in a substance use disorder treatment program? <input type="checkbox"/> Yes <input type="checkbox"/> No					
MENTAL HEALTH					
Have you ever received psychiatric mental health inpatient/outpatient treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Are you currently in treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Primary diagnosis:					
Secondary diagnosis:					
Other diagnosis:					
List any mental health hospitalizations, if any:					
Have you ever received other mental health services? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Type:		When:		Where:	
Type:		When:		Where:	
Type:		When:		Where:	

MEDICAL			
List any current medical conditions:			
Are you currently engaged in medication assisted treatment for substance abuse disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list medication: (Methadone, Suboxone, Vivitrol, etc.)			
If female, are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	What is your medical insurance status? <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> None <input type="checkbox"/> Private <input type="checkbox"/> Other:		
Do you have a history of medical conditions? If so, please list:			
List all prescribed medications below: You may attach an additional page if necessary.			
Name:	Doctor:	Dosage:	Frequency:
Name:	Doctor:	Dosage:	Frequency:
Name:	Doctor:	Dosage:	Frequency:
Name:	Doctor:	Dosage:	Frequency:
Name:	Doctor:	Dosage:	Frequency:

Name:	Doctor:	Dosage:	Frequency:
FAMILY/CHILDREN			
Number of children:	Number of children under the age of 18:		
Number of children currently involved in the child welfare system:			
Do you have custody of all your children? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A			
Do you have visitation rights of children not residing with you? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A			
Do you have contact with your primary family? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A			
EDUCATION, EMPLOYMENT, AND HOUSING			
Housing Status <input type="checkbox"/> Dependent <input type="checkbox"/> Homeless <input type="checkbox"/> Incarcerated <input type="checkbox"/> Independent			
Highest education <u>completed</u> (select one): <input type="checkbox"/> Any grade up to 11 th <input type="checkbox"/> GED <input type="checkbox"/> High School Graduate <input type="checkbox"/> Some Trade School <input type="checkbox"/> Trade School Graduate <input type="checkbox"/> Some College <input type="checkbox"/> College Graduate 2 year program <input type="checkbox"/> College Graduate 4 year program <input type="checkbox"/> Some Post Graduate <input type="checkbox"/> Advanced Degree <input type="checkbox"/> Not In School			
Current employment status (select one): <input type="checkbox"/> Unemployed <input type="checkbox"/> Employed Part Time (Less than 35 hours/week) <input type="checkbox"/> Employed Full Time (35 hours or more/week) <input type="checkbox"/> Not in labor force <input type="checkbox"/> Retired <input type="checkbox"/> Student Full Time <input type="checkbox"/> Volunteer <input type="checkbox"/> Disabled			
Primary source of support (select all that apply): <input type="checkbox"/> Adoption Subsidy <input type="checkbox"/> Disability <input type="checkbox"/> Family <input type="checkbox"/> Foster Care Subsidy <input type="checkbox"/> Retirement Plan <input type="checkbox"/> Salary/Wages <input type="checkbox"/> Social Security (SSI) <input type="checkbox"/> Social Security Disability (SSD) <input type="checkbox"/> Unemployment <input type="checkbox"/> Veterans Benefits <input type="checkbox"/> Welfare <input type="checkbox"/> Workers Compensation <input type="checkbox"/> None <input type="checkbox"/> Other:			
MILITARY HISTORY			
Have you ever served in a branch of the U.S. Armed Forces? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please answer the questions below.			
Branch:	Enlistment date:		
Discharge date:	Rank at discharge:		

Discharge type (select one): <input type="checkbox"/> Still serving, not yet discharged <input type="checkbox"/> Honorable <input type="checkbox"/> Entry level separation* <input type="checkbox"/> General (<i>includes medical</i>)* <input type="checkbox"/> Other Than Honorable* <input type="checkbox"/> Clemency* <input type="checkbox"/> Bad conduct* <input type="checkbox"/> Dishonorable* <input type="checkbox"/> Dismissal (<i>Commissioned Officer only</i>)* *Discharge details:	
Any criminal convictions prior to military service? <input type="checkbox"/> Yes <input type="checkbox"/> No	Incarcerated while in military? <input type="checkbox"/> Yes <input type="checkbox"/> No
Were you deployed abroad: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, total months: _____ Locations:	
Have you ever been exposed to military combat? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify the number of deployments: _____ Conflict Era of Service (select all that apply): <input type="checkbox"/> WW II (1941 – 1946) <input type="checkbox"/> Korea (1950 – 1955) <input type="checkbox"/> Vietnam (1961- 1975) <input type="checkbox"/> Persian Gulf – Iraq/Kuwait ODS (1990 – 2003) <input type="checkbox"/> Persian Gulf – Afghanistan OEF (2001- 2021) <input type="checkbox"/> Persian Gulf – Iraq OIF (2003 - 2010) <input type="checkbox"/> Persian Gulf – Iraq OND (2010 - present) <input type="checkbox"/> Afghanistan- Operation Freedom Sentinel (OFS) <input type="checkbox"/> Islamic State - Operation Inherent Resolve (OIS)	
Do you suffer from post-traumatic stress disorder (PTSD) because of your military service? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:	
Do you suffer from traumatic brain injury (TBI) because of your military service? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:	

Are you a victim of military sexual trauma? ☐ Yes ☐ No If yes, please provide number of times and locations:

Additional Information:

I understand that the information contained in this application is confidential and will be used solely by the Cumberland County Treatment Court team to determine my eligibility for the Treatment Court program. No information contained within this application may be used in any proceeding against me.

I further understand that I have a right to a speedy trial under the U.S. and Pennsylvania constitutions and that by applying for participation in the Treatment Court program I am waiving my speedy trial rights between the date of this application and either the date of my entry into the program or the date of my arraignment if my application is denied.

This is only an application for Treatment Court. I understand I will not be accepted into Treatment Court until the Cumberland County Treatment Court team determines I am an acceptable candidate, and I plead guilty to the crimes with which I am charged.

Date

Applicant Signature

Counsel for Applicant Signature



RELEASE OF INFORMATION

I. I, _____ (the participant), hereby consent and authorize Cumberland-Perry Drug and Alcohol Commission Case Management (the Commission) to disclose the following information:

- ☐ Whether the client is or is not in treatment
- ☐ Client diagnosis and prognosis
- ☐ Description of provider services (nature of the project)
- ☐ Brief description of client progress
- ☐ Statement of any relapse and frequency of such relapse
- ☐ ASAM Summary Sheet
- ☐ Financial and liability information
- ☐ Other: (specify) _____

II. I understand that the above information may be disclosed to: Cumberland County Treatment Court by the Commission for the sole purpose of progress monitoring and enabling support of recovery goals.

III. I, having read and consented to Part I and Part II, understand that this release of information will expire _____, or I revoke my consent by verbal or written notice to the Commission, except to the extent action has already been taken upon it.

Client Signature

Witness Signature

Date

Date

Client Copy Accepted _____

Client Copy Rejected _____

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR, Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or other drug abuse patient.

7-2018

AUTHORIZATION TO RELEASE OR REVIEW CONFIDENTIAL
HEALTH INFORMATION

Consumer's Name _____ DOB _____

I hereby authorize and request _____
to receive and to release confidential information to and from:

(Name of Physician and/or Facility/Organization to whom disclosure is being made.)

for the purpose of

☐ On-site review of consumer's health record.

☐ Copy of the following confidential information will be released for the purpose of review and evaluation.

<input type="checkbox"/> Admission Medical History	<input type="checkbox"/> Rehab – PT/OT/Speech
<input type="checkbox"/> Physical Exam	<input type="checkbox"/> Laboratory Tests from (date) _____ to
(date) _____	
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> X-ray Reports from (date) _____ to
(date) _____	
<input type="checkbox"/> Interdisciplinary Notes	<input type="checkbox"/> Consultation Reports – from (doctor's name) _____

<input type="checkbox"/> Diagnosis List	<input type="checkbox"/> Medication and Treatment Records
<input type="checkbox"/> Entire Record	<input type="checkbox"/> Physician's Orders/Progress Notes
<input type="checkbox"/> Other (please specify) _____	

The purpose of the disclosure authorized herein is to coordinate my diagnosis and treatment or supply pertinent information to other entities I deem necessary. I understand that this authorization shall remain in effect for the period indicated, not to exceed one year.

Effective Date: _____ Expiration Date: _____

If I fail to specify an expiration date, this authorization will expire in three months.

*I understand that this will include information relating to: **(check if applicable)***

☐ Medical Information

☐ Mental Health Information

☐ Drug and Alcohol Information

☐ AIDS or HIV

I understand this consent is voluntary. I know that I do not have to sign this form to receive medical care. If I do not sign this form, my doctor may not receive information that could be important to my treatment. None of the information released will be used to support any criminal charges or to conduct an investigation of me, without a court order.

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 Privacy Officer. 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.

I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Privacy Officer.

Date Signature of Consumer/Legal Representative **If signed by**
representative, relationship to Consumer

Date Witness Signature/Credentials

This information has been disclosed to you from records protected by state confidentiality rules (MH Procedures Act of 1976, as amended, and the HIV-related information act). The state rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by MH Procedures Act of 1976 as amended and the HIV-related information act. Furthermore, federal confidentiality rules (42 cfr section 2.1 et.seq.) prohibits you from making any further disclosure of this information unless disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 cfr section 2.1 et.seq. A general authorization for the release of medical or other information is not sufficient for this purpose. The state rules restrict any use of the information to criminally investigate or prosecute any mental health, and/or alcohol and/or drug abuse patient.