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do not have a current diagnosis (a diagnosis made in excess of 2 years without ongoing treatment is considered outdated), she/he must complete an appropriate psychological/psychiatric evaluation to document a diagnosis.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 form 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:

Criminal Justice Services
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: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown/Unreported	Sex assigned at birth: ☐ Male ☐ Female
Preferred gender: ☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ Gender Variant/Non-Conforming ☐ Non-Binary ☐ Other:	
Pronouns: ☐ He/Him/His ☐ She/Her/Hers ☐ They/Them/Theirs ☐ Other:	
Date of birth:	Social Security Number:
Cell phone:	Emergency Contact Name/Phone Number:
Work phone:	Email:
Primary language spoken: ☐ English ☐ Spanish ☐ Other:	
Disability Accommodations: ☐ Yes ☐ No If yes, state need:	
Living arrangements: ☐ Divorced* ☐ Living Together* ☐ Married* ☐ Single ☐ Separated* ☐ 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? ☐ Yes ☐ No

On probation? ☐ Yes ☐ No	On parole? ☐ Yes ☐ No	Probation / Parole officer's name: Agency:

Do you have any matters pending in any other court? ☐ Yes ☐ No If yes, name of court(s):

Have you ever participated in a treatment court (Drug, DUI, Mental Health, Veterans, etc.) before? ☐ Yes ☐ No If yes, name of court:

Do you have any detainers? ☐ Yes ☐ No If yes, list jurisdictions:

Are there any outstanding court orders pending against you? ☐ Yes ☐ 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? ☐ Yes ☐ No	Have you ever received substance use treatment? ☐ Yes ☐ No

Please list all treatment you have received. You may attach an additional page if necessary.

Facility	Level of Care *(Inpatient, IOP, OP, etc)*	Dates	Completed Successfully? Sobriety Time?

1st drug of choice	2nd drug of choice	3rd drug of choice

Have you ever been an IV drug user? ☐ Yes ☐ No	Are you currently an IV drug user? ☐ Yes ☐ No
Age began using drugs:	Age began using alcohol:

Are you currently in a substance use disorder treatment program? ☐ Yes ☐ No

MENTAL HEALTH

Have you ever received psychiatric mental health inpatient/outpatient treatment? ☐ Yes ☐ No

Are you currently in treatment? ☐ Yes ☐ No

Primary diagnosis:

Secondary diagnosis:

Other diagnosis:

List any mental health hospitalizations, if any:

Have you ever received other mental health services? ☐ Yes ☐ 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? ☐ Yes ☐ No If yes, list medication: (Methadone, Suboxone, Vivitrol, etc.)			
If female, are you pregnant? ☐ Yes ☐ No	What is your medical insurance status? ☐ Medicaid ☐ Medicare ☐ None ☐ Private ☐ 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:

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? ☐ Yes ☐ No ☐ N/A

Do you have visitation rights of children not residing with you? ☐ Yes ☐ No ☐ N/A

Do you have contact with your primary family? ☐ Yes ☐ No ☐ N/A

EDUCATION, EMPLOYMENT, AND HOUSING

Housing Status ☐ Dependent ☐ Homeless ☐ Incarcerated ☐ Independent

Highest education completed (select one):

☐ Any grade up to 11th ☐ GED ☐ High School Graduate ☐ Some Trade School ☐ Trade School Graduate

☐ Some College ☐ College Graduate 2 year program ☐ College Graduate 4 year program

☐ Some Post Graduate ☐ Advanced Degree ☐ Not In School

Current employment status (select one):

☐ Unemployed ☐ Employed Part Time (Less than 35 hours/week)

☐ Employed Full Time (35 hours or more/week) ☐ Not in labor force ☐ Retired ☐ Student Full Time ☐ Volunteer ☐ Disabled

Primary source of support (select all that apply):

☐ Adoption Subsidy ☐ Disability ☐ Family ☐ Foster Care Subsidy ☐ Retirement Plan ☐ Salary/Wages ☐ Social Security (SSI) ☐ Social Security Disability (SSD) ☐ Unemployment ☐ Veterans Benefits ☐ Welfare ☐ Workers Compensation ☐ None ☐ Other:

MILITARY HISTORY

Have you ever served in a branch of the U.S. Armed Forces? ☐ Yes ☐ No If yes, please answer the questions below.

Branch:	Enlistment date:
Discharge date:	Rank at discharge:

Discharge type (select one): ☐ Still serving, not yet discharged ☐ Honorable ☐ Entry level separation*

☐ General *(includes medical)** ☐ Other Than Honorable* ☐ Clemency* ☐ Bad conduct*
☐ Dishonorable* ☐ Dismissal *(Commissioned Officer only)** *Discharge details:

Any criminal convictions prior to military service? ☐ Yes ☐ No	Incarcerated while in military? ☐ Yes ☐ No

Were you deployed abroad: ☐ Yes ☐ No If yes, total months: _____ Locations:

Have you ever been exposed to military combat? ☐ Yes ☐ No If

yes, specify the number of deployments: _____

Conflict Era of Service (select all that apply):

☐ WW II *(1941 – 1946)* ☐ Korea *(1950 – 1955)* ☐ Vietnam *(1961- 1975)*

☐ Persian Gulf – Iraq/Kuwait ODS *(1990 – 2003)* ☐ Persian Gulf – Afghanistan OEF *(2001- 2021)*

☐ Persian Gulf – Iraq OIF *(2003 - 2010)* ☐ Persian Gulf – Iraq OND *(2010 - present)*

☐ Afghanistan- Operation Freedom Sentinel (OFS) ☐ Islamic State - Operation Inherent Resolve (OIS)

Do you suffer from post-traumatic stress disorder (PTSD) because of your military service? ☐ Yes ☐ No If yes, please explain:

Do you suffer from traumatic brain injury (TBI) because of your military service? ☐ Yes ☐ 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

CUMBERLAND-PERRY Drug & Alcohol COMM SS ON

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 nvestigate 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.

☐ Admission Medical History ☐ Rehab – PT/OT/Speech

☐ Physical Exam ☐ Laboratory Tests from (date) _____ to (date) _____

☐ Discharge Summary ☐ X-ray Reports from (date) _____ to (date) _____

☐ Interdisciplinary Notes ☐ Consultation Reports – from (doctor's name) _____

☐ Diagnosis List ☐ Medication and Treatment Records

☐ Entire Record ☐ Physician's Orders/Progress Notes

☐ 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.