



**SUPERIOR COURT OF NEW JERSEY**  
**Criminal Division \_\_\_\_\_ Vicinage**  
**Application to the Drug Court Program**

Date of Application	Do you need disability accommodations? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please state request:	Will an interpreter be needed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, state language:
Name		Alias
Race	Sex	Date of Birth
		Social Security Number
Current Address (Street)		Telephone Number
		Cell Phone Number
City	County	State
		Zip
How Long at this Address?	Armed Forces Veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No	Citizenship Status
Co-Habitant		Relationship
Previous Address		
Next of Kin		Relationship
		Telephone Number
SBI Number	Currently involved with DYFS? <input type="checkbox"/> Yes <input type="checkbox"/> No	Presently Incarcerated? <input type="checkbox"/> Yes <input type="checkbox"/> No
		Jail Number
On Probation? <input type="checkbox"/> Yes <input type="checkbox"/> No	Parole? <input type="checkbox"/> Yes <input type="checkbox"/> No	Probation / Parole Officer's Name
Current Charges		
County	Indictment Number	PG Number
Next court event	Date	Judge
Have you ever been sentenced to drug court before? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of court _____ When? _____		
Do you have any matters pending in any other court? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of court _____ Charges _____		
Next court event	Date	Judge
Detainers? <input type="checkbox"/> Yes <input type="checkbox"/> No	Jurisdictions	
Defense Attorney Name		Telephone Number
Defense Attorney Signature _____	Date _____	Applicant Signature _____
		Date _____

**Adult Drug Court Program**  
Superior Court of New Jersey  
Treatment Assessment Services for the Courts

**Records Release Authorization  
(Drug Court Involvement)**

I, \_\_\_\_\_, authorize  
(Name of Client)

- Treatment Assessment Services for the Courts/Substance Abuse Evaluator

**and**

- the State of New Jersey Drug Court Team (to include the Judge, defense attorney, prosecutor, Drug Court probation officers, treatment representatives, and other Drug Court team members)

**and**

- Treatment Provider/s (to be added once known):

\_\_\_\_\_  
(Name and address of treatment program)

\_\_\_\_\_  
(Date Amended)                      (Client's initials)                      (Witness' Initials)

\_\_\_\_\_  
(Name and address of treatment program)

\_\_\_\_\_  
(Date Amended)                      (Client's initials)                      (Witness' Initials)

To communicate and to disclose to one another the following information: results of substance abuse (TASC) evaluation, involvement and requirements of the Drug Court/Superior Court mandate, pertinent medical and/or psychological information, drug/alcohol screen/test results, other diagnostic test results, and

\_\_\_\_\_  
(Extent and Nature of Any Additional Information)

The purpose or need for the disclosure is **to monitor my compliance with conditions of the Drug Court/Superior Court** mandate.

I understand that this **consent cannot be revoked**, but will remain in effect until there has been a formal and effective **termination of my involvement with the Drug Court Program**.

Signature of Client \_\_\_\_\_ Date \_\_\_\_\_

Signature of Witness \_\_\_\_\_ Date \_\_\_\_\_

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 the 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 drug abuse patient.